1980

Willingness to Accept the Sick Role in Men and Women Professionals

Kimberly Evans Merrill
Loyola University Chicago

WILLINGNESS TO ACCEPT THE SICK ROLE IN MEN AND WOMEN PROFESSIONALS

by

Kimberly E. Merrill

A Dissertation Submitted to the Faculty of the Graduate School of Loyola University of Chicago in Partial Fulfillment of the Requirement for the Degree of Doctor of Philosophy

December

1980

ACKNOWLEDGEMENTS

I would like to thank Martha Brand, Mimi Bender, Shiela Lieber, Alex Aleinikoff and Tom Merrill for taking the time to solicit their co-workers for my study.

I would also like to thank the members of my committee, Dr. John Shack, Dr. Jill Nagy and Dr. Alan DeWolfe, for their support, encouragement and always helpful criticism.

VITA

The author, Kimberly E. Merrill, is the daughter of Dr. Gomer P. Evans and Shirley Mays Evans. She was born on December 26, 1948 in Pittsburgh, Pennsylvania.

Her elementary and secondary education was obtained in the public schools of Grosse Pointe, Michigan where she received a high school diploma in 1967.

In September 1967 she entered Grinnell College, and in June 1971 she received a Bachelor of Arts Degree with a major in Studio Art. In September 1974 she began her graduate work in Clinical Psychology at Loyola University of Chicago.

TABLE OF CONTENTS

LIST OF TABLES

CONTENTS OF APPENDICES

CHAPTER I

INTRODUCTION

Sex Role Identification: Its Relationship to Professional Status and Willingness to Accept the Sick Role

The past ten years have seen the publication of a number of books addressed to the task of clarifying and cataloging the differences between the sexes (Maccoby and Jacklin, 1974; Chafetz, 1974; Frieze, Parsons, Johnson, Ruble and Zellman, 1978). These works are best exemplified by Maccoby and Jacklin's, The Psychology of Sex Differences, which represents an encyclopediac effort to isolate human qualities and abilities and then weigh in the balance studies which have directly addressed the question of a sexual discrepancy. Maccoby and Jacklin review nearly 2,000 studies covering a wide range of human behavior including intellectual abilities, achievement, social relationships and emotionality. The authors are frankly dedicated to the proposition that the number and extent of real differences between men and women have been grossly exaggerated. Their aim is to dispell popular misconceptions about "innate" masculine and feminine qualities.

The significant social context in which these books have been written comprises the continuing efforts of women to acquire social, economic and political parity with men. This effort involves the assumption by women of jobs traditionally held by men. If traditional male tenure in these positions is predicated on biologically inherent superior male aptitudes, then the legitimacy of women's claim to them is diminished. If however, the allocation of positions is based on a role structure which has ceased to reflect social needs, then the obstacles to women entering masculine fields are not "legitimate" but consist of inertia and bigotry.

This is the familiar nature-nurture controversy cast in sexual terms. The nativists assert that such qualities as men's greater aggressiveness and independence are based on biological structures; the environmentalists counter that these attributes result from discrepant social attitudes and child rearing practices. The overturning of many traditional barriers to sexual equality is beginning to remove some of the factors which have made the masculine experience so much different from the feminine. The equivalence achieved by these reforms is still not 100 percent, but those situations where a basic equivalence does exist, where men and women are fulfilling essentially identical roles and responsibilities, allow researchers to focus on the examination of

allegedly innate differences between the sexes on the assumption that the factor of different environmental influences has been relatively neutralized.

The present study proposes to use the framework of similar educational and professional status to examine potential sexual differences in two basic areas of social behavior. The first area to be examined is the sex role identification of men and women occupying positions of similar status in the same professional field. The subsequent analysis will focus on the relationship between sex role identity and certain aspects of illness behavior.

The principal measure which will be employed is the Bem Sex Role Inventory, the BSRI (Bem, 1974). The central premise of the BSRI is that masculine and feminine characteristics are not mutually exclusive and that an androgynous adjustment, which allows the individual greater freedom to engage in a wide variety of behaviors, is the most desirable social sexual identity (Bem, 1975a). The present study proposes to investigate whether similar professional roles, exerting as they do similar demands, might not elicit the partial androgynous adjustment of individuals occupied in that role. The phrase, "partial androgynous adjustment," refers to the idea that men and women sharing the same professional status may not differ significantly from each other in their sex role attitudes, although they may not possess

the "ideal" equivalent balance of masculine and feminine attributes which Bem believes is characteristic of true psychological androgyny.

The preponderance of the research done with the BSRI has involved students, typically undergraduates. The student population would appear to meet one, already mentioned, criterion for the study of sex role behavior; that is, male and female students tend to share identical roles and a number of identical academic responsibilities. Yet the undergraduate, and to a lesser extent the graduate, student differs from the professional individual in that his or her personality has still not been appreciably influenced by the demands of the marketplace. The undergraduate in particular has still not experienced the powerful shaping forces of the socialization process frequently described as "professionalization." Thus, because BSRI research has focused primarily on undergraduates, the ramifications of the professionalization process on sex role identification, as conceptualized by Bem, have not received particular attention. By examining a group of individuals who have shared a highly specific socialization process, both in their professional training and in the role demands of their jobs, it should be possible to investigate the relationship between sex role and professional role.

The second major area of inquiry in the present study concerns an aspect of illness behavior which has been termed the "sick role." The sick role does not refer to the medical facts of illness or to its physiological processes but to the social ramifications of illness, to the reduced social productivity of the incapacitated individual, to his coming under medical care. According to this model, illness can be divided into two components, a physiological component which is relatively invariable and a variable social component which is subject to the influence of a number of environmental factors.

The area of illness behavior which this study will focus on concerns anxiety symptomatology, the awareness of and willingness to disclose symptoms of anxiety. While anxiety is commonly associated with the mental or psychological disorders, it should be remembered that anxiety is probably the most common reaction to the stress of other illnesses, including those which involve somatic disorders. Furthermore, since anxiety is closely associated with the discovery of illness symptoms, the willingness to disclose feelings of anxiety is closely associated with the readiness to admit illness. Both behaviors require that the individual admit to his or her own vulnerability and potential dependency or need for help. Thus, before an individual can initiate the process

which leads to the social status of being sick, the sick role, he or she must first be willing to recognize and disclose the salient symptoms of stress.

The sociological theory and research that addresses the sick role, particularly Parsons' seminal contribution, will be discussed later. For the purposes of this introduction, it is sufficient to indicate that research and statistics from diverse sources have been generally very consistent in demonstrating a discrepancy in the illness patterns of men and women, most notably in their rates of morbidity. Women "consume" significantly more medical services than men; women visit physicians more often, undergo more surgical procedures and constitute the majority of psychotherapy patients (Anderson and Anderson, 1972). Researchers investigating anxiety responses have consistently found that females score higher than males (Maccoby and Jacklin, 1974). Some researchers have accepted these statistics at face value and interpreted them to mean that women are less healty, more susceptible to stress than men. Yet a number of others have raised the question whether higher female morbidity is in fact related to women's greater readiness to accept the sick role. This readiness is related to sex role expectations for women, to their greater dependency and their greater emotional expressiveness. According to this perspective, society "holds down" the rates of male

morbidity by stigmatizing men who succumb too readily to illness or anxiety.

According to a sex role analysis, higher female morbidity rates are related to greater social tolerance of illness or weakness in women. Therefore, it might be hypothesized that roles traditionally occupied by women have made it easier for them to accept the sick role. It is arguably easier for the modern woman to retain supervisory or partially active involvement in domestic responsibilities while sick than it is for a man to fulfill his job obligations when suffering from the same symptoms of distress. It might be further hypothesized that social tolerance would not extend beyond the particular role or set of tasks and that when these change, sanctions against illness change also. Thus, women who enter professions traditionally dominated by men would not be allowed to bring their special status vis a vis illness with them. Removed from the domestic role and its associated tasks, women would cease to enjoy that margin of social tolerance regarding illness behavior. Their illnesses would be subject to the same sanctions that have long applied to men. These sanctions are directly related to the optimal functioning of the social system, specifically that part of the system which comprises the "marketplace." As Parsons has

pointed out, the health of a business system is literally dependent on the health of the individuals within it:

> ...the collective units and their achievements are of the utmost importance to the American system; for example, the business firm. But their achievements are fundamentally dependent on the capacities and commitments of the human individuals who perform the roles and the tasks within them. It is in this connection that the relevance of the valuation of health appears (Parsons, 1972, p. 119).

Role Theory: A Discussion of the Difference in Perspective between the Psychological and Sociological Theories

In the ensuing chapters, the term "role" will appear frequently. "Role" is used to characterize sexual identity, illness behavior and professional status and responsibilities. A role analysis constitutes the central theoretical basis for the present study. The widely used role concept is not rigidly defined and readily accommodates a number of different perspectives. In the present literature review a difference in emphasis will be apparent between sex role on the one hand and the sick role and professional role on the other.

The sex role theories utilized by this study share a psychological orientation; that is, they are related primarily to the individual's personality and to his or her relationships with others. Psychological role theory, following the lead of G.H. Mead (1934), has tended to emphasize the interpersonal processes

whereby a social sense of self is developed. Sociological role theory places a greater emphasis on the social group and the processes whereby the functional equilibrium between the individual and the group is maintained. Parsons points out that the role concept is a natural point of orientation for the sociologist:

> A role is the organized system of participation of an individual in a social system, with special reference to the organization of that system as a collectivity. Roles, looked at in this way, constitute the primary focus of the articulation and hence interpenetration between personalities and social systems (Parson, 1972, p. 109).

The sick role and professional role are essentially sociological constructs which emphasize the functional relationship between the individual and the system to which he or she belongs.

Sex role may even be relatively unique in psycological role theory in that it tends to constitute a "mega role," more intimately related to an individual's identity than other more discrete roles and often incorporating these roles. Sex role has been called the "master status" (Gove & Tudor, 1973) which channels the individuals into certain roles and determines the quality of his or her social interactions. As if taking their inspiration from Jung's anima and animus, theorists have tended to formulate masculine and feminine sex roles almost as archetypes, as universal and very broadly drawn dichotomies. For example, in his formulation of

sex differences in ego functioning, Gutmann (1965) proposed that male and female functions develop in and are coordinated to significantly different habitats: the female environment is group oriented while the masculine environment is individualistic and objective. Bakan (1972) related masculinity and feminity to the concepts of agency and communion which he described as the two fundamental modalities in the existence of living forms, "agency for the existence of the organism as an individual and communion for the participation of the individual in some larger organization of which the individual is a part."

A number of psychological researchers have attempted to locate sexual identity in a more empirical context; the measures developed by these psychologists including the BSRI will be discussed in greater detail in Chapter II. These measures tend to be descriptive elaborations of stereotypical masculine and feminine attributes; they do not relate sex role identity directly to social functions or responsibilities. Yet it is relatively apparent that sex role formulations have their origins in the distinct traditional familial functions of men and women. At the same time, however, sex role expectations are not limited to relationships within the family but extend to a number of extra-familial relationships. Thus, while women's maternal functions give them the more nuturant and

affiliative role in the family, in extra-familial relationships women are also expected to be more sympathetic and "better listeners" than men.

Despite the difference in emphasis, it is possible to relate sex role to the more specific sociological role constructs which will also be utilized in this study. An individual's social identity can be characterized in terms of a role hierarchy. As the "master status" sex role would constitute the principal role in this structure. The second level would consist of the primary social roles which are the cornerstones of the individual's social identity. Men have traditionally held two principal roles at this level, the professional and the domestic, while women have been limited to the domestic role. Membership in additional organizations affords both men and women the opportunity to assume a number of minor roles which would constitute the third and even fourth levels of this proposed hierarchy. The sick role can also be located in this hierarchical structure. As will be explained in greater detail in Chapter II, the sick role functions as a kind of substitute role which sanctions the individual's derelection of his normal role responsibilities during periods of medically recognized illness.

It might be further proposed that while the various levels in this role hierarchy can be conceived as

separate entities, they also have an interdependent existence whereby changes at one level can affect the roles at other levels. The present study is interested in the relationship between the sex role and the socialization process in the professional role. The second major area of inquiry is the relationship between sex role identification and willingness to accept the sick role.

The profession which will be examined here is the legal profession. While not necessarily the most competitive field in which to gain educational and professional admission, the legal profession from law school onward is, in America, intensely competitive, placing a high premium on characteristics such as aggression, confidence and drive which are considered to be distinctly masculine. It might be expected that insofar as identification with masculine characteristics is concerned, men and women lawyers would not differ. For the same reason, very little difference between the illness behavior of men and women attorneys would be expected. As a minority group, women lawyers are frequently considered to be under greater stress than their male colleagues and for this reason alone might be expected to admit to a higher degree of anxiety symptomatology. However, the operating assumption in the present study is that the task demands facing individuals of similar status will prevail over other factors in determining illness behavior.

This concludes the introductory overview. The ensuing chapters will focus on the role theories which underly the measures and provide the theoretical framework for the present study. Chapter II examines the development of the BSRI in the context of other measures which have been developed to measure Masculinity/Femininity. In Chapter III, Parsons' theory of the sick role is discussed with reference to research on social factors in illness behavior. Chapter IV presents the actuarial evidence for higher female morbidity and reviews a number of explanations for this apparent difference.

CHAPTER II

THE BEM SEX ROLE INVENTORY: ITS DEVELOPMENT AND RELATIONSHIP TO OTHER MEASURES OF SEX ROLE IDENTITY

The Problem of Construct Validity in the Early Masculinity-Feminity (MF) Scales

With the publication of the BSRI, Bem introduced a novel concept to the measurement of Masculinity-Femininity, MF (Bem, 1974). She proposed that masculine and feminine characteristics did not have to be treated as a mutually exclusive attitudinal constellations. In previous instruments designed to measure MF, such as the MF scales on the MMPI (Hathaway & McKinley, 1943), the Terman Miles Attitude Interest Analysis (Terman & Miles, 1936) and the Strong Vocational Interest Blank (Strong, 1936), MF was measured along a single dimension with masculine at one end and feminine at the other. Thus, an individual who scored highly masculine was necessarily not very feminine. Bem proposed that masculine and feminine characteristics could vary independently of each other and that an individual could be both highly masculine and highly feminine.

Another factor common to the earlier scales was that they did not possess a unifying underlying theory, the absence of which led to ambiguity in what was being measured. Addressing this omission, Constantinople wrote:

> The terms masculinity and femininity have a long history in psychological discourse, but both theoretically and empirically they seem to be among the muddiest concepts in the psychologist's vocabulary. A search for definitions related to some theoretical position leads almost nowhere but to Freud and Jung (Constantinople, 1973, p. 390).

Due to this lack of theoretical clarification, there was a tendency among the early MF psychometrists to interpret MF in terms of biological sex and to use as a primary criterion for item selection the item's ability to discriminate the responses of males from those of females. However, this expedient was not problem free for, as Constantinople explains, "The strictly empirical approach to test construction would seem to lead to an even muddier concept, since anything that discriminates men from women ... is taken as an indicator of MF with no assessment of the centrality of that trait or behavior to an abstract definition of MF."

This lack of theoretical clarification led researchers and developers to re-examine the instruments, to investigate what exactly was being measured. Subsequent analyses tended to reveal that while unidimensionality was implicit in the scoring procedure, factor analyses of the items indicated multidimensionality of the MF trait.

Thus, in the Terman Miles Attitude Interest Analysis, which consists of seven exercises, the relatively low intercorrelations between these exercises led Terman and Miles to believe that it was pointless to search for general factors through factor analysis (Terman & MIles, 1936). In the MMPI, Dahlstrom and Walsh (1960) noted that the item content of the MF scale is very heterogeneous; they identified five factors while Graham, Shroeder and Lilly (1971) found seven.

In her review of MF measures, Constantinople calls particular attention to a study by Nichols (1962) which she believes contributes a useful clarification for the construction of an MF measure. In this study, Nichols evaluated 356 items from popular MF scales along two dimensions; one dimension reflected actual sex differences, the extent to which items successfully discriminated males from females; the second dimension reflected social stereotypes, the extent to which items discriminated social expectations for masculine versus feminine behavior. Nichols constructed a scatterplot along these two coordinates and identified three types of items: (1) obvious items, high on both stereotypic and actual discrimination, (2) subtle items, high on actual but low on stereotypic discrimination, and (3) stereotypic items, high on stereotypic discrimination but unable to discriminate actual sex differences as successfully as the

other two. Constantinople concluded from Nichols' study that stereotypic items constitute a contaminating factor in many popular MF instruments and that what is needed is a means of controlling them.

The theoretical underpinnings and the construction of the BSRI could be interpreted as turning Constantinople's argument on its head. As opposed to eliminating stereotypic items, the BSRI is essentially composed entirely of such items, as will be evident later on when the construction of the BSRI is examined. Thus, the BSRI represents a departure from earlier measures of MF, since it makes no attempt to measure MF in its totality. It does, however, measure a delimited but crucial aspect of MF; that is, the extent to which individuals incorporate stereotypic masculine and feminine attributes into their self concepts. Considerable research has demonstrated that individuals do identify, in varying degrees, with sex role stereotypes. The BSRI provides an instrument whereby the ramifications of this identification can be examined.

The Research of McKee and Sherriffs: Defining Basic Parameters of Sex Role Expectations

The critical early work in producing a sex role, as distinct from an MF, measure was done by McKee and Sheriffs (1953, 1957a, 1957b, 1959). Their work was

stimulated by an incidental finding by Sheriffs and Jarrett (1953) which revealed a systematic preference for males on the part of both males and females. McKee and Sherriffs proceeded to make a systematic examination of this finding, addressed to the following issues:

> What are the parameters of sex role expectations and what is the extent of their acceptance? Do men and women agree on the norms for sexually appropriate behavior?
>
> What is the social desirability or value of sex role characteristics? Do men and women agree in rating the overall desirability of masculine and feminine characteristics?
>
> To what extent are these stereotypes incorporated into an individual's self concept?

In order not to artifically constrain the selection of sex role characteristics, McKee and Sherriffs used both open and closed methods of item selection in constructing their measures. In the closed choice procedure students were asked to take Sarbin's adjective checklist three times with the following instructions: (1) Check items true of women, (2) Check items true of men, and (3) Check whether the item is more characteristic of men or women. Items identified by the researchers as sex role characteristics were selected 95 percent of the time as being more characteristic of one sex. The nature of the selection criterion which isolated extreme items led McKee and Sherriffs to label these characteristics stereotypes. The items selected by this procedure were then evaluated

in terms of a specially compiled social desirability rating.

McKee and Sherriffs found a high degree of agreement between men and women regarding the typical characteristics of males and females. Both sexes agreed that, among their favorable characteristics men were informal, industrious, calm, logical, individualistic and aggressive; their less favorable characteristics included boastful, stubborn, hard-headed and reckless. Concommitantly, both sexes agreed that women were poised, tactful, sociable, modest, affectionate, understanding and sensitive; among women's unfavorable characteristics were snobbish, submissive, vain, touchy, fearful, superstitious and frivolous.

When the overall social desirability of these characteristics was examined, it was found that both men and women were significantly more positive toward masculine than to feminine items. This preference was consistent throughout all methodological variations in item selection. McKee and Sherriffs noted that this preference did not reflect a negative overall valuation of women, but the fact that the masculine items had a higher overall positive valuation.

McKee and Sherriffs also noted a general tendency for men and women to be much more critical of the typical female than they were of the typical male. In their

descriptions of a typical man, males were, in McKee and Sherriffs' words, "lavish with praise," and it seemed that men's negative characteristics were limited to an excess of their favorable qualities. Women essentially agreed with this highly favorable picture. Women, on the other hand, tended to be highly critical of the typical woman and seemed to emphasize female neuroticism. Men were also very critical of women.

Finally, McKee and Sherriffs examined men's and women's self concepts to determine the extent to which they incorporated sex role stereotypes. Using Sarbin's list, students were asked to describe their: (1) Ideal self, (2) Actual self, (3) Ideal opposite sex individual, and (4) Ideal same sex individual (according to the expectations of the opposite sex). Results showed that men and women did not include as many stereotypic items in their self descriptions and tended to endorse the more favorable items. When beliefs about the opposite sex were examined, it was found that men believe women want them to possess favorable qualities of both sexes about equally. This belief indeed reflected the characteristics that women desire in the ideal man. However, women's beliefs about what men expect were found to be even more stereotypically feminine than men's actual preferences. This led McKee and Sherriffs to conclude

that women exaggerate the extent to which men wish to restrict them from characteristics which are thought to be masculine.

The work of McKee and Sherriffs provided the basis for much of the subsequent research into the nature and ramifications of sex roles. They established that sex role stereotypes do exist and claim a wide acceptance. Following McKee and Sherriffs, sex role research has tended to focus on the relatively negative social valuation of feminine characteristics and the detrimental effects to women arising from this valuation.

Other Sex Role Measures and Research on Sex Role Stereotypes

Using an item selection and rating procedure similar to the one developed by McKee and Sherriffs, Rosenkrantz, Vogel, Bee, Broverman and Broverman (1968) developed a Sex Role Stereotype Questionnaire. They found that masculine characteristics were more highly valued than feminine; this differential valuation was a function of that fact that more masculine than feminine characteristics were highly valued. They constructed their scale to reflect this differential, and, of 41 stereotypic items on the scale, 29 were masculine and 12 were feminine. Given the greater overall social desirability of the masculine items, Rosenkrantz et al. expected that

in their own self descriptions women would, as a function of social desirability, tend to incorporate many masculine items. They found that while men's and women's self concepts were less masculine and less feminine respectively than the stereotypic profile for a member of their own sex, both sexes nonetheless perceived themselves as differing along the dimension of stereotypic sex differences. This finding that individuals do align themselves along stereotypical dimensions led the authors to observe that, "the factors producing the incorporation of the female stereotype with its negative valuation must be extremely powerful."

Other researchers have investigated the negative consequences occurring to women as a result of incorporating stereotypic sex role expectations. Block (1973) examined the effects of sex role typing and socialization on men and women. Her results suggested to her that the socialization process has a differential effect on the development of sexual identity in men and women. For males, socialization seems to encourage a more androgynous sex role adjustment; whereas the socialization of women tends to discourage the development of masculine tendencies. Furthermore, Block found that while highly masculine males tended to be well adjusted and successful, among women, the most successful were the low feminine females.

The idea that sex typing is more detrimental to women was supported by the work of Heilbrun (1964, 1968). Using a social deviance theory of adjustment, Heilbrun (1964) hypothesized that sex typed individuals (individuals who conform to social norms for appropriate sex role behavior) would be more well adjusted than non sex-typed individuals. Heilbrun found that this hypothesis was supported for males in a number of studies; however, the evidence for the same hypothesis in terms of women's adjustment was found to be scarce. After reviewing nine studies, Heilbrun concluded, "If any trend can be adduced, it would be that feminity in females is associated with poorer adjustment."

In another study, Heilbrun (1968) compared masculine and feminine women along the dimensions of instrumental and expressive behaviors. These dimensions were selected because they seemed to epitomize the constellations of behavior that are stereotypically described as masculine and feminine. Heilbrun found that whereas both groups were essentially equal along the expressiveness dimension, masculine women scored significantly higher on the instrumental dimension. Heilbrun concluded that the better adjustment of the masculine women could be traced, not to their lack of feminine characteristics, but to their incorporation of masculine, instrumental characteristics such as goal orientation, assertiveness, dominance, etc.

Using the Fand Sex Role Inventory, Gump (1972) examined the career plans of senior college women. She found that women with a traditional orientation did not differ from women primarily interested in realizing their own potential either in terms of general adjustment or interest in establishing relationships with men. She did find however, a tendency for differences in ego strength to be associated with plans for marriage and a career. Women who obtained the highest ego strength scores were actively pursuing both objectives, whereas low scorers tended to be more dependent and unable to sufficiently remove themselves from the context of their present situation to identify their needs and realistic and appropriate means of meeting them. This finding led Gump to raise the possibility that ego strength may be negatively related to the adoption of the traditional female sex role.

Broverman and her colleagues found that the prevailing notions of mental health reflect the social standards of sex role stereotypes (Broverman, Broverman, Clarkson, Rosenkrantz and Vogel, 1970). Using the Sex Role Stereotype Questionnaire, they asked clinicians to describe one of three individuals, a healthy, competent, socially mature (1) adult, sex unspecified, (2) man, (3) woman. They found that the characteristics of a healthy individual differ as a function of the sex of the person judged and that behaviors and characteristics which are healthy for an adult, sex unspecified, which are

presumed to reflect an ideal standard of health, resemble behaviors judged healthy for men but differ from behaviors judged healthy for women. Thus, clinicians are more likely to suggest that healthy women differ from healthy men by being more submissive, less independent, less adventurous, more easily influenced, less aggressive, etc.

In general, it seems that one characteristic common to much of the earlier sex role research was a tendency to emphasize the detrimental effects to women arising from their identification with feminine sex role values and their failure to incorporate masculine sex role values. Much less effort seems to have been spent exploring the potential detriment to men of sex role typing or some of the less favorable ramifications of stereotypic masculine characteristics. Thus, it might be argued that the researchers have perpetuated and supported the idea of the negative worth of feminine sex role characteristics despite the fact that certain studies suggest that men benefit from the possession of feminine sex role characteristics. Mussen (1962) found that although in adolescence highly masculine boys tended to be better adjusted than less masculine boys, when these groups were evaluated years later, the latter, less masculine group was more successful and well adjusted. Block noted that for males socialization seemed to enhance an androgynous adjustment. The research of Heilbrun and Gump indicates that while successful, professionally oriented women gain from

incorporating masculine characteristics, they do not significantly differ from feminine women in their identification with and interest in many feminine values.

The Development of the Bem Sex Role Inventory

The trend in more recent sex role research seems to be toward the proposition that both masculine and feminine values should be accorded equal social worth and that the possession of a high quantity of both characteristics allows for the optimal social adjustment. The Bem Sex Role Inventory can be seen to epitomize this new direction in sex role research.

The BSRI does not address the issue of the social desirability of masculine versus feminine items. Social desirability is strictly controlled in this scale; that is, both sets of items have been judged to be equally socially desirable. No effort was made, as with the Sex Role Stereotype Questionnaire, to incorporate into the scale the difference in social desirability between masculine and feminine items. In the first step in developing the BSRI, Bem (1974) compiled a list of 200 personality characteristics which she felt to be positive in value and either masculine or feminine in tone. This list was then given to a group of judges who were asked to rate, on a seven-point scale, the desirability of all

characteristics either for a man or a woman; no judge was asked to rate both. A personality characteristic qualified as a sex role characteristic if it was independently judged by both male and female judges to be significantly more desirable for one sex ($p < .05$). Of those characteristics which satisfied this criterion, 20 were selected for the masculinity scale and 20 for the femininity scale. In the actual test form of the BSRI, the individual is asked to indicate on a seven-point scale how well each of the characteristics describes her or himself. On the basis of this responses, the individual receives two scores, a masculine score and a feminine score.

According to the original criterion for androgyny established by Bem, individuals who received low scores on both masculine and feminine scales were not distinguished from individuals who received high scores on both scales.[1] In response to criticisms from Spence (Spence, Helmreich and Stapp, 1976) and Strahan (1975), Bem

---

[1] In the original presentation of the BSRI (Bem, 1974), the examiner was instructed to derive an androgyny $\underline{t}$ score for the masculine and feminine scores. The androgyny score was defined as the student's $\underline{t}$ ratio for the difference between the totals of masculine and feminine self endorsements. The $\underline{t}$ score was intended to allow the examiner to determine whether a person's endorsement of masculine attributes was significantly different than his endorsement of feminine attributes. Androgynous individuals were defined as those who received a $\underline{t}$ score of less than the absolute value of one.

altered her original scoring techniques. Bem adopted Strahan's suggestion of using a simple difference score, as opposed to a *t* score, to determine the difference between the masculine and feminine scales. Spence observed on the basis of her research that individuals who receive high masculine and high feminine scores are different from those who receive low scores on both scales and that only the former are properly labeled androgynous. Spence suggested that the low-low group is more accurately described as "undifferentiated." Bem's own research indicated to her that this demarcation was warranted, and she now recommends that the masculine and feminine scores of the entire population be divided along a median split and the individuals accordingly grouped into four categories: (1) Low Feminine-Low Masculine, (2) High Feminine-Low Masculine, (3) Low Feminine-High Masculine, (4) High Feminine-High Masculine.

Normative research on the BSRI was done with Stanford undergraduates and volunteers at Foothill Junior College. Coefficient alpha was computed separately in each of the samples in order to estimate internal consistency; the results showed both scales to be highly reliable, with the two coefficients for the masculine scale both equal to .86, while the two coefficients for the feminine scale were .80 and .82. Test-retest coefficients also indicated a high degree of reliability,

with coefficients for both scales equal to .90. In the normative sample males were found to score significantly higher than females, on the masculine scale, while the reverse was true for the feminine scale.[2]

Bem conducted a number of studies to evaluate the validity of the concept of androgyny as measured by the BSRI. In one study, she selected two behaviors which seemed to typify stereotypical expectations for masculine and feminine behavior: independence and gentle playfulness (playing with a kitten). She found that for both males and females, masculine and androgynous subjects were more independent than feminine subjects. In the second

---

[2]According to the original criteria for defining androgyny, approximately 35% of all subjects fell into the androgynous category. When computed by the classification system advocated by Spence, the partition is necessarily closer to 25 percent.

As defined by Androgyny *t* ratio:

Sex Role	Males	Females	Total
Feminine	.08	.20	.14
Near Feminine	.11	.18	.14
Androgynous	.30	.41	.36
Near Masculine	.21	.13	.17
Masculine	.30	.09	.20

As defined by median split:

Sex Role	Males	Females	Total
Feminine	.16	.34	.25
Masculine	.37	.16	.25
Androgynous	.21	.29	.25
Undifferentiated	.27	.20	.25

(Bem and Watson, Scoring Packet: Bem Sex Role Inventory, 1976 pp. 20, 21)

activity however, the hypothesis was confirmed only for male subjects; that is, androgynous and feminine males played more with the kitten than masculine males. Among females, sex role preference did not predict amount of time spent playing with the kitten.

In another study, Bem evaluated assertiveness and personal concern as respectively masculine and feminine traits. In the assertiveness condition, students were asked to take part in an experiment without pay. Feminine females found it more difficult to say no than masculine and androgynous females. There were no differences according to sex role among the male subjects. In the personal concern condition, the researchers evaluated the subjects for sympathy as a listener. Masculine males were considerably less nurturant and sympathetic than feminine and androgynous males. Masculine and androgynous females were not as nurturant as feminine females but were as nurturant as feminine males.

Based on these experiments and others, Bem concluded that there is empirical evidence to support the validity of her scale and the proposition that strict sex role typing can be behaviorally restricting. It appeared clear that androgynous individuals of both sexes possessed the greatest behavioral flexibility.

CHAPTER III

THE SICK ROLE AND RESEARCH IN THE SOCIOLOGY OF ILLNESS

The Sick Role According to Parsons

Almost three decades have elapsed since Parsons presented his theory of the relationship of illness to society in his major work, The Social System (1951). The presentation of illness as deviance which society has a vested interest in controlling served as a catalyst to theory and research in the sociology of illness. His ideas led to close functional analyses of diverse agencies in the health care system, of medical education, of the hierophantic aspects of the doctor's status and the treatment relationship and of the sometimes antagonistic functioning of different staff groups within large mental hospitals. Parsons' theory of the sick role has become so well known that it has achieved the greying eminence of a major contribution whose limitations have been revealed by extensive subsequent research. One critic notes, "the concept of the sick role has been carried to absurd extremes" (Mechanic, 1968). For purposes of the present study, however, certain aspects of Parsons' theory are relevant and will constitute the focus of the ensuing chapter.

The central concept of the sick role is that illness is a form of deviance, by definition harmful to the optimal functioning of society. The sick role is the means whereby the social system attempts to mitigate and control the harmful effects of illness. Parsons does not propose that the incidence of illness is completely controllable by social action, but insofar as it is controllable, it is clearly in the interest of society to effect this control through such mechanisms as the sick role. Parsons delineated four social features that characterize the sick role:

> The incapacity is treated as beyond the individual's power to overcome by the process of decision making alone; in this sense he cannot be "held responsible" for the incapacity. Some kind of therapeutic process, spontaneous or aided, is conceived to be necessary for recovery.
>
> The incapacity, defined as illness, is interpreted as a legitimate basis for the exemption of the sick individual, to varying degrees, in varying ways and for varying periods according to the nature of the illness, from his normal role and task obligations.
>
> To be ill is thus to be in a partially and conditionally legitimated state. The essential condition of its legitimation, however, is the recognition by the sick person that to be ill is inherently undesirable, that he therefore has an obligation to "get well" and to cooperate with others to this end.
>
> So far as spontaneous forces, the vis mediatrix naturaé cannot be expected to operate adequately and quickly, the sick person and those with responsibility for his welfare, above all, members of his family, have an obligation to seek competent help and to ccoperate with competent agencies in their attempts to get him well (Parsons, 1972, p. 117).

The first feature of the sick role makes the point that the incapacity itself is regarded as beyond the individual's powers of control and that "even though he may have become ill or disabled through some sort of carelessness or negligence, he cannot legitimately be expected to get well simply by deciding to be well or by pulling himself together." Thus, illness is distinguished from other forms of deviance such as disloyalty or the violations of legal norms which involve the voluntary violation of social expectations. Parsons points out that illness as deviance is similar to the religious status of ritual impurity or sin in that neither health nor the state of grace may be achieved through willed action. Neither illness nor sin can be escaped without recourse to some outside curative or restorative agency.

The second feature defines the relationship between the sick role and other social roles. An individual who attempts to avoid certain role obligations without the protection of some social sanction can only expect to receive censure directed at returning him to the job. The sick role is a status which designates that its occupant is conditionally relieved from the obligations of his or her particular role. It is a socially legitimate role and sanctions the deviance of its occupant. Parsons believes that the singularly thorough, scientific training of the medical doctor qualifies him to be the

sole authority over the dispensation of sick role statuses. An individual cannot, without encountering social resistance, assign the sick role to himself, at least for any extended period of time. Mechanic observes that there are circumstances under which the sick role is highly coveted as an escape from extremely grueling or hazardous responsibilities.

> Under combat conditions when manpower is at a premium, it becomes increasingly more difficult for an individual to have his claims for disability accepted and legitimized. To move into our own backyard, the university, it is evident that students frequently attempt to use the excuse of illness to justify failure to meet their academic responsibilities (Mechanic, 1968, p. 289).

The suggestion that the availability of sick role clearances is not always inelastic and unrelated to the functional needs of the system is clearly demonstrated in Soviet Russia where, in order to protect economic production, the government has restricted the number of illness clearances that physicians could grant during a given period of time. Recent revelations about Soviet psychiatric practices reveal the ominous use of the sick role to deliberately isolate and ostracize politically suspect individuals from "healthy" society.

The sick role, despite its reprieve from the drudgery of many daily responsibilities, is not an unambiguously desirable role. There is a definite stigma attached to being ill; it places the incapacitated

individual in a position of enforced dependency on the healthy, in a position of needing help. This implicit stigma is the third feature of the sick role and is crucial to the social control of illness. Bloom and Wilson provide a dramatic statement of the undesirable aspects of the sick role:

> There are properties of being ill that threaten the integrity of the person. He who adopts the sick role, for whatever reason, feels himself at least temporarily less than whole, weakened, open to incursions of fear and trembling (Bloom & Wilson, 1972, p. 116).

The sick person is alienated both physically and philosophically from the healthy community. To the healthy working world, the sick person is a pariah. The sick person is frequently socially insulated; Parsons points out that the reasons for this insulation are two-fold:

> Motivationally as well as bacteriologically, illness may be contagious. The motives which enter into illness as a deviant behavior are partially identical with those entering into other types of deviance ... Thus the important feature of insulation is the deprivation for the sick person of any claim to a more general legitimacy for his pattern of deviance (Parsons, 1972, p. 118).

Parsons refers to Durkheim in advancing a further function of the social insulation of the ill; as in the case of crime, "the designation of illness as illegitimate is of the greatest importance for the healthy, in that it reinforces their own motivation not to fall ill." The

alienation which the incapacitated experience is essentially alienation from the achievement oriented expectations that motivate the healthy working majority.

The final feature of the sick role concerns the obligation encumbent on the sick person to seek technically competent help and to cooperate fully with the authorities in achieving his cure. Therapeutically, recovery is defined for the patient as his "job." The goal of treatment is to reintegrate the patient into society, to remotivate him toward achievement and the acceptance of his role responsibilities.

Evidence for the Influence of Multiple Social Factors on Illness Behavior

The impact of Parsons' theory of the sick role on research in health and illness has been considerable, and it has inevitably come under considerable critical scrutiny. One criticism particularly relevant to the present study involves the contention that Parsons' sick role is deficient in that its interpretation of illness behavior is unimodal. Gordon (1966) succinctly articulates the drawbacks of the unimodal approach:

> Although Parsons recognizes that people differ in their reactions to illness, he attributes such differences to variations in emotional response. Whenever responses differ from those that Parsons has postulated, they are viewed as deviations from a norm ... One consequence of the assumption of unimodality is that variations in role conception

> will likely be attributed to psychological rather than to social factors, and the possibility that such variations are structurally related to the social system is either neglected or denied (Gordon, 1966, p. 20).

Parsons is not particularly interested in how individuals arrive at the sick role status or the possibility that individual differences in this process may have a basis in different social structures. For Parsons, illness is most essentially a biological state with social implications and consequences. As a biological state, illness is invariable. The sick role is conceived as a separate motivational step which allows for choice and variable behavior, but Parsons argues that this variability should be submitted to the strict control of the medical profession which by virtue of its achieved scientific expertise determines what order and degree of symptoms merit the imposition of the sick role. Any variation which occurs between individuals, in selecting the services of a physician, in manner of presenting symptoms, is interpreted as random variation, not as a consistent effect of identifiable social factors.

Contrary to Parsons' assumption of unimodality, a number of researchers working is disparate sections of the health field have demonstrated consistent relationships between illness behavior and certain social factors. In his study of a small town in New York, Koos (1954) found that social class was significantly related to attitudes

toward illness and readiness to seek help. The lower socioeconomic group was sharply distinguished from the middle and upper income groups by its tendency to disregard symptoms of illness and to rely on less scientific forms of treatment. In the area of mental health, Dohrenwend and Dohrenwend (1969) investigated relationships between certain categories of psychopathology and socioeconomic class. They found that the lowest social class yielded the highest number of schizophrenics whereas the highest rates for manic depression were located in classes other than the lowest. Other disorders, such as the neuroses, were distributed relatively evenly throughout all classes. Character disorders were found predominantly in the lowest class.

Ethnicity has been a widely researched variable in the sociology of illness behavior. Because religious boundaries often interact with national boundaries in the formation of ethnic groups, both factors are typically considered in the definition of ethnic boundaries. Croog (1961) administered the Cornell Medical Index to 2000 army industees. He found that Italian and Jewish respondents reported the greatest number of symptoms of illness. Among the Italian respondents, Croog observed that symptom report was associated with low educational status; however, this relationship was not observable among the Jewish group. Zborowski (1958) interpreted

these findings in terms of "illness training" received in childhood. He noted that both Jewish and Italian correspondents related that their mothers showed over-protective and over-concerned attitudes toward the child's health. Furthermore, both cultures encourage the free expression of feelings of emotions. However, Zborowski believed that the cultures differed in that Italians have a present oriented apprehension with regard to the actual experience of pain, while Jews show a future oriented anxiety as to the meaning of the pain experienced. Both groups are contrasted with "old American" patients who try to take a detached, unemotional view of their symptoms.

Mechanic (1963) examined student willingness to use the health services at two universities.[3] Jewish students at both universities reported a higher tendency to make use of the physician than Protestant or Catholic students. Mechanic hypothesized that illness behavior among Jewish populations might reflect an alternative adaptive device in the absence of regular church attendance and religious ritual which are much more predominant

---

[3]The primary measure of illness behavior used at both universities concerned the willingness of students to consult a physician in three hypothetical illness situations: feeling poorly and having no temperature, feeling poorly and having a temperature of 100, and feeling poorly and having a temperature of 101.

in the Protestant and Catholic religions. However, Mechanic was unable to relate church attendance to use of health services.

Zola (1964) suggested that different cultures evolve distinctive styles for handling illness symtomatology and its attendant stress. He compared Irish and Italian Catholic patients in a Boston outpatient clinic. He found that the Irish tended more than the Italians to deny that pain was a feature of their illness; they showed a tendency to limit and understate the difficulties associated with the illness and to deny that it had affected their well being. Zola interpreted these differences in symptom selection and presentation in terms of culturally preferred solutions for dealing with stress. He suggested that dramatization is an Italian ego coping mechanism whereas the Irish, whose view of life emphasizes the omnipresence of sin, tend to see illness as something to be endured, perhaps as retribution for past sin.

Suchman (1964) hypothesized that social structure was the crucial variable in determining different ethnic attitudes toward illness. He interviewed residents in the Washington Heights community in New York city in a sample that included Negros, Puerto Rican, Jews, Protestants, Catholics and Irish born Catholics. The interview tapped three major areas of medical concern, (1) knowledge of disease and prevention (2) attitudes toward medical

care, (3) response to illness. Suchman's results showed the greatest contrast between Puerto Ricans on the one hand and white Protestants and Jews on the other. In most aspects of health knowledge, attitudes and behavior, the Puerto Rican group stood out as most divorced from the methods and objectives of modern medicine and public health, while the Protestants and the Jews were most in accord with them.

Suchman hypothesized that the more ethnocentric and cohesive the social group, the more isolated and alienated it will be from the larger society and the less likely it will be to accept the objectives and methods of the formal medical care system. He constructed an in-group identification index composed of five measures: (1) ethnic exclusivity, (2) friendship solidarity, (3) social group cohesiveness, (4) family tradition and authority orientation, (5) religious attendance. He found that the most parochial group, the Puerto Ricans, adhered to the most popular, nonscientific health orientation. Even with socioeconomic factors controlled, within each ethnic and socioeconomic group, parochialism continued to be associated with a popular, nonscientific, health orientation. Regarding the sick role, Suchman found that the greater the degree of family orientation to tradition and authority, the greater the difficulty in

assuming the sick role; this was particularly true for the Irish, Puerto Ricans and Negros.

These studies while differing in their particular interpretations of individual differences in readiness to assume the sick role are alike in that they share a sociological interpretation of these differences. Mechanic and Volkart (1961) formulated a psychological model of sick role readiness. They proposed that there are two components involved in illness behavior: stress and willingness to accept the sick role.[4] The authors define stress generally to comprise all stressors, biological and environmental, which place heavy or conflicting demands on the individual. Willingness to accept the sick role is seen as multiply determined, involving such factors as age, sex, religion, ethnicity, the individual's position in his social group as well as the importance of his role to that group.

Mechanic and Volkart developed a stress scale which focussed on feelings of isolation and aloneness which they believed are particularly indicative of stress among adolescents. This scale along with a scale which measured inclination to adopt the sick role[5] were

---

[4]Mechanic and Volkart make a clear distinction between the development of illness states, a physiological process, and the act of coming under medical care. They emphasize that they are interested in the second phenomenon which they define as illness behavior.

[5]See footnote 3.

administered to a sample of sophomore males at a large midwestern university. Health records for the previous year were examined to determine the number of visits each student made to the university health service. Results showed that the frequency of medical visits was associated with both perceived stress and the tendency to adopt the sick role; furthermore, these two factors were also positively related. However, when stress was controlled, the tendency to adopt the sick role continued to exert a significant effect on actual medical visits, leading Mechanic and Volkart to conclude that while frequency of medical visits is a function of both variables; in general, the tendency to adopt the sick role is the more significant.

Mechanic and Volkart imply that an individual sick role predisposition score could theoretically be derived from a composite of social factors; however, they do not explain the relationship of their scale to these variables. There are a number of other factors which also influence illness behavior, the epidemiological frequency of the illness and its familiarity, the predictability of illness outcome and the threatened loss likely to result.

In conclusion, the principal purpose of this chapter was to present the theoretical background for the Parsonian sick role, as distinguished from the physical illness process, in light of research which

reveals the effects of certain social factors on the process of social labeling involved in the sick role. The research of Koos, Suchman, Dohrenwend and others indicates that variability in patterns of illness is not merely random or the product of individual psychological differences, but is attributable to the effects of recognizable social factors. In the following chapter, evidence for the interpretation of sex role as a factor in sick role readiness will be reviewed.

CHAPTER IV

SEX ROLES AND ILLNESS BEHAVIOR

The Evidence for Higher Female Psychiatric Morbidity

In their review of adult sex roles and mental illness, Gove and Tudor (1973) note that incidence of greater female psychiatric morbidity is a relatively recent phenomenon. They observe that prior to World War II, more men than women with psychiatric disorders were admitted to mental hospitals (Landis and Page, 1938; Goldhamer and Marshall, 1953; U.S. Bureau of Census, 1930, 1941). In their examination of social class and psychiatric disorder, Dohrenwend and Dohrenwend (1969) reviewed 23 community studies relating to the sexual distribution of psychosis. Of the 12 studies which were conducted after World War II, all showed higher rates for women; eight of the pre-World War II studies showed higher rates for men; three showed higher rates for women.

According to a survey of the consumption of general health services conducted by Anderson and Anderson (1972), higher female morbidity is not confined to psychiatric disorders but applies to a wide spectrum of physical disorders as well. They examined HEW statistics for 1963

relating to use of short term hospitalization, physicians' services, number of surgical procedures and dental care and found that women consistently had a higher rate of utilization than men. This imbalance does not reflect a bias due to maternity care as it was sustained even after maternity services were controlled. More recent government surveys indicate that women report more symptoms and visit doctors more often than men (U.S. Dept. of H.E.W., 1973). Women are more likely to restrict their activities or spend a day in bed because of illness (White, Williams and Greenburg, 1961; Hinkle, Redmont and Plumer, 1964).

Due to the fact that the present study is specifically focused on readiness to accept the sick role particularly as this is related to admission of anxiety symptomatology, it is important to take a closer look at the research and commentary on the sexual imbalance in psychiatric morbidity. In their research with the now well known Midtown Manhattan Project, Srole, Langner, Michael, Opler and Rennie (1962) found that women admitted to significantly more symptoms of mental distress than men, both in terms of psychological and physiological symptoms. In a study conducted for the Joint Commission on Mental Health and Illness, Gurin, Veroff and Field (1960) reported the following information for nonhospitalized American adults:

> Greater distress and symptoms are reported by women than men in all adjustment areas. They report more disturbances in general adjustment, in their self perception and in their marital and parental functioning.
>
> A feeling of impending breakdown is reported more frequently by divorced and separated females than by any other groups of either sex.
>
> While the sexes did not differ in the frequency with which they reported unhappiness, the women reported more worry, fear of breakdown and need for help.

Women seek psychiatric or psychological treatment in greater numbers than men. William and Schofield (1963) found that the average psychiatrist sees significantly more female than male patients. Buhn, Conwell and Hurley (1965) published a study which reported that female patients outnumber male patients 3:2 in private psychiatric practice. Gove and Tudor (1973) were able to locate five studies (three related to European medical practice) which reported sex distributions for private psychiatric practice; all five showed higher rates of females in treatment. In a recent article on psychotherapy, Sobel (1980) stated, "Women outnumber men two to one as patients/clients/analysands."

The National Institute of Mental Health has conducted a series of surveys on psychiatric morbidity in the United States examining the variability according to sex, age, race and type of treatment facility. A 1970 survey examined patients in the following types of psychiatric

facilities: state and county mental hospitals, private mental hospitals, community mental health centers, general hospital inpatient psychiatric units and outpatient psychiatric services. In 1970, a total of 2,254,850 patients were admitted to these psychiatric facilities; 1,104,531 admissions were male; 1,150,349 were female. The authors note, however, that V.A. hospitals were not included in this count and that had the 97,000 psychiatric admissions to V.A. hospitals in 1970 been included, they would have produced an overall excess of male to female admissions in a ratio of 104 to 96. For all other facilities, however, except for the state and county mental hospitals, which constitute about 20 percent of all psychiatric admissions surveyed, women admissions outnumbered men with the greatest differences occurring in the private mental hospitals and general hospital inpatient psychiatric units where there were only 69 males per 100 females. Comparable ratios for community mental health centers and outpatient psychiatric services were 88 and 99 respectively. (See Table 1).

A second exception to the male-female ratio in the 1970 survey concerns nonwhite admissions. For nonwhites, male admissions exceeded female admissions in three of the four facilities, the exception being community mental health centers. A color-sex breakdown of admissions to private hospitals for nonwhites was not conducted since

TABLE 1

UTILIZATION OF PSYCHIATRIC FACILITIES

BY SEX IN 1970

		Sex Ratio (Males per 100 Females)
Total--All Facilities	2,254,880	96
Male	1,104,531	
Female	1,150,349	
State and County Mental Hospitals	459,523	149
Male	274,761	
Female	184,762	
Private Mental Hospitals	87,000	69
Male	35,502	
Female	51,498	
Community Mental Health Centers	334,760	88
Male	156,573	
Female	178,187	
General Hospital Inpatient Psychiatric Unit	507,904	69
Male	207,309	
Female	300,595	
Outpatient Services	865,593	99
Male	430,386	
Female	435,307	

this group constituted a very small proportion, about 4.5 percent, of the total admisstions to these hospitals.

Leading diagnoses for men and women patients upon admission were different. Among women, the depressive disorders were the most frequently reported diagnosis (24.1%), followed by schizophrenia (18.4%) and transient situational disturbances (9.1%). The leading diagnoses among men were alcohol disorders (16.3%), schizophrenia (15.8%) and depressive disorders (10.8%). (See Table 2).

The last year for which the U.S. Department of Health, Education and Welfare compiled statistics on psychiatric morbidity was 1975. The mental health treatment facilities examined were: (1) Nonfederal general hospital psychiatric inpatient units (public and nonpublic), (2) State and county mental hospital inpatient services, (3) Private mental hospital inpatient units, (4) Community mental health centers, and (5) Outpatient psychiatric services.

In 1975, a total of 3,355,708 patients were treated at these facilities.[6] Of these, 1,589,948 patients were male; 1,765,760 were female. (See Table 3). Thus, a total

---

[6]The criteria for determining number of patients varied somewhat from institution to institution. The patient statistics for nonfederal general hospitals were determined by number discharged, while private and state mental hospitals reported the number of admissions.

TABLE 2

LEADING DIAGNOSES FOR MALE AND FEMALE PSYCHIATRIC PATIENTS IN 1970

	Total	Male	Female	Male/Female Ratio
Total All Diagnoses	2,254,880	1,104,531	1,150,349	96
Alcohol Disorders	227,755	180,379	47,376	381
Drug Related Disorders	67,559	44,799	22,760	197
Organic Brain Syndromes*	107,658	55,589	52,069	107
Schizophrenia	386,065	174,093	211,972	82
Depressive Disorders**	396,136	119,149	276,987	43
Other Neuroses	153,920	57,452	96,468	80
Personality Disorders	200,707	104,770	95,937	109
Transient Situational Disturbances	208,376	103,469	104,907	99
All Other Disorders	506,704	264,831	241,873	109

*Excluding Drug and Alcohol Intoxication

**Psychotic and Neurotic

TABLE 3

UTILIZATION OF PSYCHIATRIC FACILITIES BY SEX AND RACE IN 1975

	Total			White			Nonwhite		
		Male	Female		Male	Female		Male	Female
Nonfederal General Hospital Psychiatric Inpatient Units	515,537	211,569	303,968	450,992	184,219	266,773	64,545	27,350	37,195
Public	139,352	70,910	68,442	112,641	57,305	55,336	26,711	13,605	13,106
Nonpublic	376,185	140,659	235,526	338,351	126,914	211,437	37,834	13,745	24,089
Outpatient Psychiatric Services	1,406,065	634,355	771,710	1,171,196	528,794	642,402	234,869	105,561	129,308
State and County Mental Hospitals	385,237	248,937	136,300	296,151	109,788	105,363	89,086	58,149	30,937
Private Mental Hospitals	129,832	55,706	74,126	119,356	50,727	68,629	10,476	4,979	5,497
Community Mental Health Centers	919,037	439,381	479,656	761,848	362,402	399,446	157,189	76,979	8,0210

TOTALS:

All Patients:	3,355,708	White Patients:	2,799,543	Non-White:	556,165
Male	1,589,948	Male	1,316,930	Male	273,018
Female	1,765,760	Female	1,482,613	Female	283,147

of 175,812 more female than male patients received some form of psychiatric treatment. Women outnumbered men in all of the facilities examined except for public non-federal general hospitals and state and county mental hospitals where the ratios of males per 100 females were 104 and 183 respectively. (See Table 7) Female patients outnumbered male patients by the largest ratios in non-federal nonpublic general hospitals (100:60) and in private mental hospitals (100:75). (See Table 7) These same patterns essentially prevailed for nonwhite patients, but the discrepancies were less extreme.

Leading diagnoses for men and women patients were different. (See Tables 4 and 5) Among females, the depressive disorders were the most frequently diagnosed (23%), followed by schizophrenia (15%) and transient situational disturbances (11%). The leading diagnoses among men were schizophrenia (16%), alcohol disorders (15%) and depressive dosorders (12%). A glance at Table 6 shows that women outnumbered men in all diagnostic categories except alcohol disorders, drug disorders, personality disorders, retardation and childhood disturbances.

It is significant to note that higher rates of psychiatric morbidity for females are not observed at all age levels. In fact, in the youthful age range, there is a consistent tendency for males either to equal or

TABLE 4

LEADING DIAGNOSES FOR MALE PSYCHIATRIC PATIENTS IN 1975

BY TYPE OF TREATMENT FACILITY

	Total	General Hospital	Private Hospital	CMHC's	State & County	Outpt. Services
All Disorders	1,589,948	211,569	55,706	439,381	248,937	634,355
Alcohol Disorders	232,095	25,979	8,081	69,665	87,977	40,393
Drug Disorders	53,209	7,621	1,844	18,785	11,169	13,790
Organic Brain Syndromes	47,572	8,074	2,183	11,161	10,811	15,343
Schizophrenia	258,942	57,754	12,201	46,204	73,472	69,311
Depressive Disorders	189,912	60,831	18,754	37,171	21,741	51,415
Other Neuroses	53,806	12,439	3,559		2,192	35,616
Other Psychoses	14,945	5,013		8,894	1,038	
Transient Situational Disturbances	174,678	10,792	4,542	65,238	11,445	82,661
Personality Disorders	108,670	15,013	3,266		19,477	70,914
Retardation	22,101			17,719	4,382	
Social Maladjustment	69,201		113	26,224		42,864
Childhood Disorders	101,158	2,142	895			98,121
No Mental Disorder	142,849		301	62,408		80,140
Other	122,113	5,911	1,272	75,912	5,233	33,785

TABLE 5

LEADING DIAGNOSES FOR FEMALE PSYCHIATRIC PATIENTS IN 1975

BY TYPE OF TREATMENT FACILITY

	Total	General Hospital	Private Hospital	CMHC's	State & County	Outpt. Services
All Disorders	1,765,760	303,968	74,126	479,656	136,300	771,710
Alcohol Disorders	63,706	9,953	2,746	19,637	18,638	12,732
Drug Disorders	32,944	10,288	1,233	9,853	3,266	8,304
Organic Brain Syndromes	50,240	10,907	3,012	11,282	9,561	15,478
Schizophrenia	263,471	66,704	16,112	45,710	55,953	78,992
Depressive Disorders	408,203	133,568	36,314	85,777	23,224	129,320
Other Neuroses	107,270	19,631	3,726		3,736	80,177
Other Psychoses	19,343	6,584		10,294	2,465	
Transient Situational Disturbances	200,695	15,737	4,542	55,404	7,548	117,464
Personality Disorders	93,683	15,087	3,350		6,909	68,337
Retardation	16,259			13,284	2,975	
Social Maladjustment	140,491			40,171		100,414
Childhood Disorders	48,491	2,483	669			45,339
No Mental Disorder	149,875		538	72,156		77,181
Other	54,916	13,086	1,833		2,025	37,972

TABLE 6

RATIO OF MALE TO FEMALE PATIENTS BY DIAGNOSIS

		M/F Ratios
All Disorders	3,355,708	.90
Alcohol Disorders	295,801	3.64
Drug Disorders	86,153	1.62
Organic Brain Syndromes	50,240	.95
Schizophrenia	522,413	.98
Depressive Disorders	598,115	.47
Other Neuroses	161,076	.50
Other Psychoses	34,288	.77
Transient Situational Disturbances	375,373	.87
Personality Disorders	202,353	1.20
Retardation	38,390	1.36
Social Maladjustment	209,513	.49
Childhood Disorders	149,649	2.09
No Mental Disorders	292,724	.95
Other	177,029	2.22

TABLE 7

RATIO OF MALE TO FEMALE PATIENTS

BY TREATMENT FACILITY

M/F Ratios by Facility	
Nonfederal General Hospital	.69
Public	1.04
Nonpublic	.60
Outpatient Services	.82
State & County	1.83
Private Hospital	.75
CMHC's	.92

outnumber females in treatment facilities.[7] This accords with the 1975 statistics for childhood disturbances where males outnumber females by a ratio of slightly better than two to one. Raskin and Golob (1966) observed that male psychotics were hospitalized earlier than female psychotics. They concluded that this was due not to an earlier manifestation of symptoms, but to a quicker response by society to symptoms in men.[8]

---

[7]For the 1975 data, presented in Tables 2 through 5, the following male-female ratios were observed for the age ranges extending to 34:

	Male/Female Ratio			
Institution	Under 15	15-17	18-24	25-34
State Mental Hosp.	*	1.83	2.70	2.03
Outpatient Serv.	*	1.74	.82	.60
Private Mental Hosp.	*	.97	1.05	.69
Commun. Mental H.C.	1.58	1.01	.87	.78
Gen. Hosp. Psych. Unit.	*	*	*	.88

*No data available.

[8]Despite the significant age difference between the sexes, male and female patients in this present study did not differ significantly on time of first recognizable psychotic episode or signs of early psychic disturbance. In other words, study males did not evince symptoms of psychiatric illness at an earlier age than study females. Rather, there was a shorter gap between recognizable psychotic behavior and hospitalization for study males than for study females. Although empirical data on this point are not available, differences in social role expectations could account for this gap. In our society men are expected to assume the role of breadwinner. Consequently, as compared with female family members there is a greater likelihood of family disruption, consternation and pressure from family members for treatment, including hospitalization, when a male member of the family is forced to remain at home because of psychiatric illness. (Raskin & Golob, 1966, p. 18)

These figures do not necessarily contradict a sex role analysis of higher female morbidity. The analysis employed in the present study places particular emphasis on the role responsibilities of adult men and women. While boys and girls are from the outset socialized differently regarding such issues as stoicism and independence, these values are not buttressed by specific work expectations until early adulthood. Generally, both male and female children in our society enjoy a unique and extended vacation from work responsibilities other than academic.

Regarding the early onset psychoses, it should be noted that they have traditionally been considered the most severe mental disorders with the poorest prognoses. They may, by virtue of their severity, leave little margin for the self selection involved in the sick role. A 19 year old acute schizophrenic can do little to disguise the fact of his or her condition. It is noteworthy that there is no sexual discrepancy in the number of patients being treated for schizophrenia. Furthermore, the period of greatest risk for schizophrenia occurs before the age of 34 whereas depression is much more a pathology of the middle years. Depression is also characterized by a much better prognostic outlook than schizophrenia, and the depressed individual arguably has greater control over his or her disorder.

Interpreted in terms of a hypothetical underlying distribution of psychopathology, these statistics might be taken to indicate that the population levels of serious psychopathology for both sexes are essentially equal or even that men are more vulnerable than women. However, in the area of the less severe, more marginal disorders where the sick role with the variability involved in self selection and presentation of symptoms has a wider area to operate social expectations and leniency regarding dependency in the female sex role may result in higher female morbidity rates. Parsons emphasizes that the sick role is a mechanism which functions to insure that the man hours lost from the work place for reasons of illness are limited to that which is necessary to the recuperation of the patient. It might further be expected that the more valuable the worker to the business enterprise, the more stringent the internalized sanctions against any appearance of dependency or weakness on his part. Accordingly, the duties of a typical contemporary housewife or low status female employee might accommodate themselves much more easily to "pampering oneself when sick" or yielding to weakness than the expectations placed on the average male employee. It is significant to note that in those social classes where the strict work ethic does not prevail; that is, those groups served by state and county mental hospitals and public general hospitals,

men equal or outnumber women patients in psychiatric treatment facilities.[9]

Accounting for the Phenomenon of Higher Female Psychiatric Morbidity

The sexual discrepancy in psychiatric morbidity has not gone unobserved by a number of different writers and authorities in the field of mental health. In 1919, Bleuler, referring to greater institutionalization of women, wrote:

> It is still an open question, and a very important one, whether women really have a greater tendency to nervous diseases or whether the opportunities for leading a parasitic existence constitute the real reason for their greater neurotic morbidity. (Bleuler, 1919, pp. 43-44)

Szaz quotes this passage with approval in Schizophrenia: The Sacred Symbol of Psychiatry (1976). In a chapter entitled, "Psychiatry and Matrimony: Arrangements for Living," Szaz goes on to indict the mental hospital as an extension of the nunnery as an institution for controlling women:

> Since the enlightenment the role of the nunnery has been replaced in part by that of the madhouse or mental hospital; every woman still had to be in a domicile owned and controlled by a man or men--if not in her husband's home, then in a "mental home" (Szaz, 1976, p. 149).

---

[9] It is relevant here that a large proportion of individuals treated by V.A. hospitals are also unemployed.

Szaz further proposes that the present day relationship between the female patient and the male hospital psychiatrist is essentially modeled after the traditional Victorian marriage, "arranged for the partners by the superiors of their respective clans." He points out that the psychiatric-matrimonial relationship defines and legitimizes the condition and status of each partner, the schizophrenic-incompetency of the patient-wife and the scientific-authority of the psychiatrist-husband.

It is not surprising that feminists writing on the subject of women and madness would refer to Szaz as a sympathetic authority. The feminist ideology interprets higher female symptomatology, therapy utilization and hospitalization as directly related to women's status as second class citizens in modern society. Thus, traditional forms of therapy cannot "cure" neurasthenia--symptomatic of a slave mentality--because they are essentially bulwarks of a system which reinforces women's unequal status.

In a study surveying 1,000 middle income clinic outpatients, Chesler (1971) found that of the patients who expressed a specific sex preference, both men and women showed a significant preference for male over female therapists. This preference was significantly related to marital status in women but not in men. Specifically, single women preferred a male therapist significantly

more often than a female therapist and significantly more than having no sex preference. This finding led Chesler to conclude that women may seek psychotherapy for very different reasons than men, notably because "psychotherapy along with marriage is one of the only two socially approved institutions for middle-class women." Chesler elaborates on the parallel features of both institutions:

> For most women the psychotherapeutic encounter is just one more instance of an unequal relationship, just one more opportunity to be rewarded for expressing distress and to be "helped" by being (expertly) dominated. Both psychology and marriage isolate women from each other; both emphasize individual rather than collective solutions to women's unhappiness; both are based on a woman's helplessness and dependency on a stronger male authority figure; both may, in fact, be viewed as re-enactments of a little girl's relation to her father in a patriarchal society; both control and oppress women similarly, yet at the same time are the two safest havens for women in a society that offers them no others. Both psychotherapy and marriage enable women to safely express and defuse their anger by experiencing it as a form of emotional illness, by transmitting it into hysterical symptoms, frigidity, chronic depressions, phobias and the like (Chesler, 1971, pp. 751-52).

A number of other authors have noted and attempted to account for that same morbidity statistics observed by Chesler. Radloff (1976, 1978) draws parallels between depression, the most frequently diagnosed psychological disturbance among women, and stereotypic expectations for feminine behavior. She refers to Beck's cognitive model of depression (Beck & Greenberg, 1974) which focusses on unrealistic ideas of helplessness. She points out that

many of the signs of helplessness symptomatic of depression--pessimism, self blame, indecision, susceptibility to external influence, weakness--are actually to be found in the checklists of studies of female sex role stereotypes.

Radloff believes that greater depression in women is a result of the "image of helplessness" which is fostered in women through parents, teachers, T.V. programs and commercials, children's literature and textbooks and finally, psychotherapists. In their review of dependency behavior, Maccoby and Masters (1970) found that girls are seen as more fragile and are helped more than boys; parents also seemed to pay more attention to boys achievement behavior. Sternglanz and Serbin (1974) reviewed children's programs and found that the male children were more aggressive, constructive and got more rewards for actions. The psychotherapists studied by Broverman et al. (1970) saw the healthy female as less independent, less easily influenced, more excitable in a minor crisis--in a word, more helpless--than the healthy male.

One conclusion which would appear to follow from the feminist perspective reviewed here is that mental illness or disturbance is not a socially neutral phenomenon and should not be regarded as such; what it is essentially is an indictment of weakness, a "slave mentality," an inability to wrest from life coveted rewards and

satisfactions. The "destigmatization" of mental illness, which has been one of the hallmarks of the modern mental health movement, would appear to have been jettisoned for more circumscribed ideological goals. It had been believed that in order for mentally disturbed individuals to receive the treatment they needed, it was necessary to remove the onus from being in therapy. Psychiatric disorders were presented as problems which might happen to anyone at some time or another in an effort to move away from the popular imputation of a shameful moral or genetic stain.

Szaz, Radloff and Chesler would appear to share the perception that women are actually less mentally healthy than men. They attribute this inequality variously to differential socialization and political status. The idea that the contemporary female sex role has resulted in poorer psychological adjustment for women receives a comprehensive overview in an article by Gove and Tudor (1973). At the outset of their review, the authors take pains to define what they understand by mental illness; that is, "a disorder which involves personal discomfort (as indicated by distress, anxiety, etc.) and/or mental disorganization (as indicated by confusion, thought blockage, motor retardation, and, in the more extreme cases by hallucinations or delusions) that is not caused by an organic or toxic condition." It is immediately evident that these diagnostic criteria would prevent such categories

as personality disorders, drug and alcohol addictions from being labeled as mental illness. Whatever the nosological merits of these distinctions, the relevant implications for the present study are that men overwhelmingly outnumber women in these categories and that excluding them from the census inevitably skews the final tabulation toward a disproportionate number of women receiving psychiatric treatment.[10] In order to achieve a nosological purity, Gove and Tudor were willing to ignore the features of social parity implicit in treatment received by similar professionals at similar institutions, be it for alcohol abuse or depression.[11]

Gove and Tudor surveyed NIMH and V.A. censes up to the year 1967 as well as a number of individually

---

[10]The authors relied on NIMH data for 1967. To take a more recent example, if organic brain syndromes, alcohol and personality disorders are removed from the 1970 census for both men and women, a total of 340,738 cases are removed from the male total while only 195,382 are removed from the female total. The difference of 145,356 cases would by itself be sufficient to nullify the effect of the V.A. admissions for 1970, which according to the HEW survey gave male cases a slight edge (104:96) over female cases for that year.

[11]Furthermore, there is some evidence that these diagnoses may not be as far apart as they superficially appear. Apart from psychoanalytical formulations which identify similar dynamic configurations at the root of each, researchers at Washington University (Winokur, Reich, Rimmer and Pitts, 1970) investigating the genetic basis of alcoholism have found that in many families where the males show a high incidence of alcoholism, the females show an elevated rate of depression.

conducted studies relating to community and private psychotherapeutic care. They found that for all treatment facilities examined, women had a higher rate of psychiatric disturbance than men. The authors interpret this differential as resulting from the unsatisfactory role statuses of most women relative to most men. In support of their position they marshall a varied body of evidence. Having concluded that the most clear-cut difference between male and female psychiatric morbidity occurs among married individuals and that single men are generally less healthy than single women,[12] Gove and Tudor place particular significance on the housewife role. They point out that while men have traditionally held two primary roles, women have had only one. Furthermore, the decrease in family size, increasing urbanization and time and labor saving modern technology have all contributed to the status attrition of the housewife role. Many women are overeducated for this relatively low status role and could well be expected to be dissatisfied with it. The authors note further that even when the married woman works, she is typically in a less satisfactory position

---

[12]For the year 1970, among married patients, women show a higher rate of disturbance, while among the never married, males are consistently more disturbed than the females. Widowed men seem to do slightly better than widowed women, while the figures for separated and divorced individuals tend to be essentially equal. (Statistical Note #81)

than the married male. Women are discriminated against in the job market and they frequently hold positions that are not commensurate with their educational backgrounds (Harrison, 1964; Epstein, 1970; Kreps, 1971). Like men, women are beginning to assume two primary roles, but unlike the situation for men, social expectations for women continue to pit the domestic and professional roles against each other. Finally, Gove and Tudor call attention to sex role research which has demonstrated that the feminine stereotype is less highly valued than the masculine stereotype (McKee & Sherriffs, 1957; Rosenkrantz, Vogel, Bee, Broverman & Broverman, 1968).

Gove and Tudor emphasize their belief that the raised level of female morbidity reflects actual differences in psychological health.

> We have argued that the women's role in modern industrial societies has a number of characteristics that may promote mental illness and have explored the possibility that in such societies, women have higher rates of mental illness than men (Gove & Tudor, 1973, p. 831).

The authors take pains to dissociate themselves from what they call the "societal reaction" and the "women are expressive" perspectives according to which higher female psychiatric morbidity results from social expectations for women. Gove and Tudor seem to be attempting to divorce sex role expectations from an analysis of mental health. Accompanying the relatively "debased"

status of women which Gove and Tudor have identified as existing in the last 30 years, there have been social expectations of greater feminine vulnerability and dependency and a concommitant greater social tolerance for women seeking therapeutic assistance.

Phillips and Segal (1970) have investigated the relationship between sexual status and psychiatric symptoms from the societal expectation perspective. Using the Langner Mental Health Scale, they examined 302 individuals over the course of a year for physical and psychological disturbances. They found that more than one third of the female subjects received a score of four or more on the Langner compared to only one fifth of the male respondents. They found that the single greatest predictor of psychological disturbance was number of physical illnesses. However, women's mental disturbance scores increased more rapidly with number of physical symptoms than men's. Thus, under roughly equivalent circumstances of objective physical illness, women were more likely than men to report feelings and behavior which were seen by mental health investigators as signs of psychological disturbance. Furthermore, when the researchers examined the utilization of medical facilities, they found that a higher percentage of women sought help.

In an earlier study, Phillips (1964) had investigated the hypothesis that society may reject men more

harshly than women for exhibiting "mentally ill" behavior. Phillips also examined type of help source and nature of presenting symptoms as they affect social rejection. Phillips found that individuals who seek no help are rejected least, followed by those who seek help from a clergyman, physician, psychiatrist and finally, mental hospital. Regarding the effect of symptomatology on rejection, Phillips found that social rejection is more influenced by degree of deviance than the extent of psychopathology. Thus, a depressed neurotic was rejected more than a simple schizophrenic. Finally, concerning the influence of sex on social rejection, in 23 out of 25 comparisons, the male was rejected more than the female. Phillips discusses the implication of this finding for treatment:

> This finding also has implications for the willingness of men and women to seek help for their illness. If a man in our society is expected to be better able to cope with his illness and is rejected for not doing so, he may be more hesitant to make his illness public by seeking professional help. The difference in the use of medical facilities ... may not reflect a true discrepancy in the number of men and women who are "really" sick, but ... distinctions in the role prescriptions for men and women (Phillips, 1964, p. 686).

In this statement, Phillips refers to a hypothetical underlying "true" level of mental illness which is essentially equivalent for men and women. The appearance of greater female morbidity is thus interpreted as an artifact resulting from differential role prescriptions

not from a psychiatric etiology. There is another branch of epidemiological research which also suggests that in terms of overall health, women are not more vulnerable than men. Mortality statistics show a significant discrepancy between men and women in favor of the latter. This is a relatively recent phenomenon:

> The sex differential in mortality has increased strikingly over the past half century in the U.S. In 1920, the life expectancy for women was 56, only two years longer than that for men. By 1970, women's life expectancy was 75, almost eight years longer than men's. In 1920, male death rates were no more than 30% higher than female death rates at any age. By 1970, male death rates exceeded female death rates as much as 180% for 15 to 24 year olds and 110% for 55 to 64 year olds (Waldron, 1970, p. 349).

Among young adults, the excess in male mortality is due primarily to accidents; at the older ages, cardiovascular and renal diseases make the largest contributions to higher mortality in men. Significantly more men than women die of respiratory diseases and cirrhosis of the liver. The etiology of these disorders can partially be related to behavior patterns which are considered particularly masculine (or even "macho"). Thus, higher male mortality due to accidents can be traced to riskier driving habits, more dangerous working conditions, higher accidental drownings and accidents caused by firearms.

> It is evident from these statistics that men's higher accident fatalities are a result of behaviors which are encouraged in boys and men: driving, working at sometimes hazardous jobs, using guns, being adventurous and acting unafraid. The expectations that

> boys will be more adventurous and take more risks than girls and women is conveyed by the stories children read (Waldron, 1970, p. 354).

Men's greater consumption of alcohol is also responsible for higher accidental deaths as well as deaths due to cirrhosis of the liver. Men smoke more than women, and research suggests that cigarette smoking is the primary cause of disproportionate male lung cancer and emphysema mortality. Cigarettes also make a substantial contribution to coronary heart disease. The total pathological effect of smoking, particularly the elevation of coronary heart disease, lung cancer and emphysema makes a major contribution to the sex differential in total death rates. For middle-aged adults who have smoked regularly, men's mortality exceeds women's by only 30% compared to a male excess of 120% for the entire sample. Since relatively few people begin smoking cigarettes after age 20, until recently it has been possible to attribute higher smoking among males to greater rebelliousness among male teenagers as well as earlier mores which severely criticized female smoking.

In addition to greater male recklessness, drinking and smoking, a number of researchers feel that there is another factor in higher male mortality rates which is directly related to the more intense, aggressive and competitive masculine professional role. Research has specifically implicated this factor in coronary heart

disease, and it has been labeled the "Coronary Prone Behavior Pattern" or "Type A" behavior. A person shows the Type A behavior pattern if he or she is work-oriented, ambitious, aggressive, competitive, hurried, impatient and preoccupied with deadlines (Jenkins, 1971).

> The coronary prone behavior pattern is considered to be the overt behavioral syndrome or style of living characterized by extremes of competitivness, striving for achievement, aggressiveness (sometimes stringently repressed), haste, impatience, hyper-alertness, restlessness, explosiveness of speech, tenseness of facial musculature and feelings of being under the pressure of time and the challenge of responsibility. Persons having this pattern are often so deeply committed to their vocation that other aspects of their lives are relatively neglected. Not all aspects of this syndrome or pattern need be present for a person to be classified as possessing it. The pattern is neither a personality trait nor a standard reaction to a challenging situation, but rather the effect of a challenging situation on a characterologically predisposed person (Jenkins, p. 309, 1971).

Many of these qualities are recognizable characteristics of the masculine sex role stereotype; this raises the hypothesis that men have more coronary heart disease than women, in part because the Type A behavior pattern is more prevalent among men.

These statistics might be interpreted as indicating that women are, in fact, healthier than men. More conservatively, they suggest that behaviors associated with masculine sex role attitudes are more hazardous to health than behaviors associated with the feminine sex role. It is important to underscore, however, that these epidemiological trends are subject to change. One significant

change for women is that they are beginning to exhibit more masculine mortality patterns. Smoking and lung cancer are on the increase among women. The picture for suicide is beginning to change also; in certain areas, women's suicide rates are beginning to approach those of men's. Women physicians and psychologists have suicide rates three times higher than women in general and as high as the suicide rates of men in their professions (Steppacher & Mausner, 1974; Mausner & Steppacher, 1973).

Thus, it would appear that sex roles mediate illness behavior as well as actual susceptibility to certain types of illness. Furthermore, this mediating influence is modified by new social demands on behavior. The present study focuses on a very delimited area of illness behavior; that is, the willingness to disclose anxiety symptomatology which can also be seen as a general willingness to disclose concern about states of health. Due to demonstrated social expectations for female illness behavior, it would be expected that ordinarily the female group would exhibit greater illness behavior and would appear more anxious. The group of women under investigation in the present study is not, however, an ordinary group; it is not so much the fact of their employment that sets them apart as the status of their employment. The women under investigation generally earn the same salaries and share the same status and responsibilities

of their male colleagues. The performance expectations placed on them by their superiors are essentially identical. It is expected that these circumstances of professional role will exert a significant effect not only on the sex role identities of these women but also on their willingness, vis a vis their male colleagues, to accept the sick role.

CHAPTER V

SUMMARY AND HYPOTHESES

The purpose of the present experiement is to investigate the relationship between sex role identification and illness behavior in terms of a modified Parsonian sick role analysis. Parsons developed the concept of the sick role to explain how social systems minimize and control loss of productivity due to illness. The sick role was intended to apply equally to all citizens; any variations in patterns of illness were interpreted as random psychological variation. However, a number of researchers have demonstrated that identifiable sociological variables exert a significant influence on patterns of illness behavior. Factors such as religion, social class and ethnicity have been related to whether an individual will respond to a symptom, the extent to which he will complain about it and the likelihood of his seeking treatment for it.

Sex has been identified as a factor which influences illness and illness behavior. In the past 30 years there has been a general tendency for women to report a higher number of physical and psychiatric symptoms than men and for women to avail themselves of medical and

psychiatric treatment more frequently. This discrepancy has been observed and interpreted by a number of authorities in the health field. Some researchers appear to suggest that women are congenitally less healthy than men (Anderson and Anderson, 1972; Gurin, Veroff and Field, 1960). Other researchers have proposed that women's higher rates of morbidity do not reflect a real difference in health but rather a tendency for women to be more aware of their physical and mental states and their greater willingness to express their anxiety about a possible dysfunction. This greater expressiveness has been related to women's greater expressive and nurturant functions within the family (Phillips and Segal, 1969; Phillips, 1964).

A number of writers have suggested that women's higher psychiatric morbidity is directly related to the psychological malaise suffered by women in contemporary society as a consequence of their status as second class citizens (Chesler, 1971; Szaz, 1976). Researchers have pointed out the parallel features of the depressive syndrome and the female stereotype (Radloff, 1976, 1978). It has also been proposed that the ambiguous and conflicted status of many female roles may cause psychological problems for many women (Gove & Tudor, 1973). The housewife role is increasingly regarded as an inadequate full time occupation for women, yet women who enter

the job market frequently find themselves with less pay and less responsibility than their male co-workers (Harrison, 1964; Epstein, 1970; Kreps, 1971). On the average, women's salaries are two thirds that of men's (Ferriss, 1971).

Phillips has suggested that society is more tolerant of illness and weakness in women and does not reject them as harshly for exhibiting illness behavior (Phillips, 1964). Phillips does not, however, offer any explanation as to why this differential rejection should occur. In his analysis of the sick role, Parsons has pointed out that ostracism and rejection are important features of the sick role which exert a powerful incentive for the incapacitated individual to return to his or her normal, healthy productivity. He does not address the possibility that these sanctions might be applied differentially according to the status of the worker or the nature of the work. It seems evident, however, that the sanctions against illness placed on the elderly or the very young are not as severe as those placed on a mature adult in the prime of his productive years. A number of writers have alluded to another possible factor affecting the social ostracism of the incapacitated individual; that is, the nature of the work that he or she performs (Gove & Tudor, 1973; Mechanic, 1961). An individual's work may be regarded as less valuable to the general enterprise

or the worker may be regarded as replaceable. This situation would seem to characterize the work of many low level female employees. The nature of the work may allow the worker to "slow down" during periods of physical and psychological incapacitation without markedly affecting the ongoing functioning of the enterprise. It is much easier for a housewife to "let things go" than it is for a salaried worker who is typically not his own boss.

It is the premise of the present study that women have exhibited a higher overall morbidity, not because they are more oppressed or expressive than men, but because the characteristics of their traditional and typical salaried roles have exerted less pressure on them to stoically deny their illnesses and anxieties. There is some indication that this relative social tolerance for women to exhibit greater concern for their health may have paid dividends in terms of significantly higher female longevity (Waldron, 1974). However, one price women may have had to pay for the greater social tolerance for their illness behavior may have been their exclusion from the financially rewarding positions of power and prestige occupied by men. With the advent of women entering the professions and competing with men for financial and psychological rewards, it would be expected that women would cease to enjoy this margin of social tolerance regarding their illness behavior.

The present study intends to focus on two features of the professional woman's adjustment vis a vis her male colleagues. The first feature concerns her identification with masculine sex role values. It would be expected that the socialization process of law school and legal employment would tend to encourage the incorporation of many masculine values and attitudes and that accordingly, female attorneys would not differ significantly from their male colleagues in terms of identification with these values.

The second feature under investigation concerns illness behavior. One premise of the present study is that with individuals of similar status and responsibility, the sanctions against assuming the sick role are equal and the variability in illness attributable to the sick role is random. It is also assumed that there is no underlying difference in life stress that would contribute to differential anxiety levels between the young male and female attorneys under investigation. Therefore, it is expected that male and female attorneys will not differ in their willingness to reveal anxiety symtomatology. It is also expected that they will not differ on other measures of illness behavior.

The first phase of the data analysis will evaluate the differences between male and female groups. The second phase of the data analysis will investigate the variables contributing to illness behavior and willingness

to disclose anxiety symptomatology. Biological sex is not expected to show any relationship to illness behavior but high feminine values are expected to be positively related to it while high masculine values are expected to show a negative relationship. It is also expected that life stress will be positively related to illness behavior.

Several measures will be taken to check the basic equivalency of the two groups. Age and years out of law school will be recorded as well as stressful life events during the past year.

Hypotheses

The statistical testing of the data consists of two stages.

The first stage consists of a series of t-tests between male and female groups. It is assumed that there is no difference between the groups in age or life stress as measured by the Social Readjustment Rating Scale; these assumptions will be confirmed by the appropriate t-tests. It is expected that there will be no difference between the groups on the following measures: the BSRI Masculine Scale, the Langner Mental Health Scale, Number of Physician Visits during the Past Year, Number of Days Missed from Work due to Illness, Number of Ailments Reported during the Past Year.

Due to the fact that the no difference hypothesis does not permit any statistical inference about significance, this analysis will be supplemented by *t*-tests comparing the attorney group to Bem's Stanford normative sample for the BSRI (Bem & Watson, 1976) and a sample of undergraduates at Loyola University (Merrill, 1979). Only the female groups will be examined. It is expected that the female attorneys will exhibit significantly higher masculine sex role attitudes and significantly fewer anxiety symptoms on the Langner.

There are no norms available on the other health measures. Therefore, *t*-tests on the other three sick role measures will be interpreted "descriptively" in the context of research on the comparative morbidity rates in men and women.

The second stage of statistical testing will consist of a series of ANOVAs performed on the dependent health measures (Anxiety, Physician Visits, Work Days Lost, Ailments during Past Year). It is expected that biological sex will not emerge as a significant variable affecting behavior. It is expected that masculine and feminine sex role attitudes and stress will emerge as significant factors affecting illness behavior.

Finally, Bortner's Short Rating Scale of Type A Behavior will be administered to determine the prevalence

of the "high pressure profile" in both groups. This scale will be administered experimentally; there are no expectations as to how it might differentiate between male and female groups.

CHAPTER VI

METHOD

Subjects

Subjects for the present experiment consisted of 25 male and 25 female attorneys employed either by the Federal government or private law firms in the District of Columbia. Lawyers working for the government were drawn from the Justice Department, the Federal Trade Commission, the Justice Department's Office of Legal Counsel, the U.S. Attorney's Office and law clerks for the U.S. Supreme Court.

Measures

Due to the fact that the subjects in the present experiment were not only volunteers but busy professionals with heavy demands on their time, it was crucial that the examiner limit the test administration to as brief a time as possible. These attorneys were under no obligation to the examiner and might well have rejected the questionnaire out of hand had they found it too intrusive or time consuming. These considerations played a significant role in the selection of measures and assembly of the test booklet.

Each subject received a test booklet containing the measures and the instructions for their administration. The following tests were administered:

The Bem Sex Role Inventory (Bem, 197). Measures the extent to which the individual identifies with masculine and feminine sex role attitudes.

The Social Readjustment Rating Scale (Holmes & Rahe, 1967). Measures stressful life events during the past year. (See Appendix A)

Bortner's Short Rating Scale of Type A Behavior (Bortner, 1969). Measures the degree of the Type A profile in the individual's characteristic behavioral style. (See Appendix A).

The Langner Mental Health Scale (Langner, 1962). An anxiety index which includes psychological physiological and psychophysiological symptomatology.[13] (See Appendix A).

A Health Questionnaire. Designed by the experimenter to assess the subject's health during the past year. This questionnaire consisted of three components: Number of Ailments reported during the past year (Ailments), Number of Days Lost from Work due to Illness (Days) and Number of Physician Visits (Visits). (See Appendix A).

---

[13]While this scale was originally developed to assess overall degree of mental health, including the presence of severe psychopathology (Langner, 1962), many researchers now contend that it is more effective as an anxiety measure. Thus researchers with the Langner have found that college students score higher than predischarge ward patients (Manis, Brawer, Hunt and Kercher, 1963), that neurotics score higher than psychotics (Muller, 1971) and that the Langner correlates very highly with the Eysenck Neuroticism Scale (Shader, Ebert & Harmatz, 1971). An examination of this research led Seiler (1973) to conclude that the Langner scale was more suited as a measure of psychological distress and physiological malaise.

This scale was selected for the present study not only for its brevity but also due to the fact that research with the Langner has repeatedly shown clearcut sexual differences in degree of psychopathology.

A Brief Personal Information Questionnaire. Requests that the subject reveal his or her age, sex, years out of law school and professional legal affiliation.

Procedure

Subjects for the present experiment were volunteers whom the experimenter contacted via her acquaintance with a number of attorneys employed in the District of Columbia. Essentially there were five individuals who served as "recruiters" for the present experiment. They were instructed merely to ask attorneys of their acquaintance whether they would be willing to fill in a brief questionnaire for a friend who needed the information for a doctoral dissertation. The recruiters were not informed of the purpose of the experiment and so were not able to divulge this information to potential volunteers. Each recruiter was supplied with a number of test packets which consisted of a manilla envelope containing the tests listed in the Measures section, a brief cover letter containing a general introduction and guarantee of anonymity (See Appendix B) and a stamped envelope with the experimenter's address. Thus, after distributing the test packets, the recruiters had no further contact with them.

The experimenter attempted to delimit the potential pool of subject-volunteers with two basic instructions to the recruiters. Since the purpose of the experiment was to compare men and women, recruiters were asked to

distribute as many test packets to men as they did to women. Furthermore, the experimenter had decided to focus on young lawyers, since it is this group which contains the highest number of females, and recruiters were asked to direct their efforts accordingly.

A brief explanation should be added regarding the instructions on the Langner Mental Health Scale. Originally, it was intended as a measure of psychopathology and subjects were asked to indicate the symptoms they were currently experiencing. Subsequent research with the Langner has indicated that it is better suited as an anxiety measure (Seiler, 1973), and it is employed as an anxiety measure in the present study. Furthermore, the purpose of using the scale in the present study was not to assess degree of neuroticism but willingness to admit vulnerability to stress. In order to facilitate this admission, subjects were asked to indicate, not the symptoms which they regularly experienced but the symptoms they experienced during periods of stress.

CHAPTER VII

RESULTS

Approximately 90 questionnaires were distributed. Completed questionnaires were returned by 25 male and 26 female attorneys. (One questionnaire was randomly discarded from the female group.) The large majority (35) of the attorneys in the present study worked for the government. Twelve were employed in private practice (seven men, five women), and three were employed elsewhere.

Table 8 presents the means and t-scores for the between sex differences on the demographic and experimental variables. Men and women did not differ significantly from eath other in terms of age or years out of law school. The Social Readjustment Rating Scale indicates that there were no significant differences between men and women in terms of stressful life events experienced during the past year, although the men appeared to be under somewhat greater life stress than the women.

Regarding sex role identity, responses from the Washington D.C. attorneys examined here indicated that men and women did not differ significantly from each other on the masculine scale of the BSRI. While men scored higher than women on this scale with a mean score 5.11 to

TABLE 8

MEANS AND *t*-TESTS BETWEEN MALE AND FEMALE SUBJECTS ON ALL MEASURES

Variable	Men (n=25)	Women (n=25)	*t* Value	*p*
Age	29.92	28.44	1.70	.096
Years out of School	3.60	2.72	-1.27	.213
BSRI Masculine	5.11	4.82	1.60	.115
BSRI Feminine	4.51	4.92	-2.50	.016
Health during Past Year	2.60	4.0	-2.90	.007
Days Lost From Work	1.72	8.0	-1.69	.104
Physician Visits	1.08	2.20	-1.38	.180
Anxiety Symptoms	4.60	5.80	-1.26	.213
Life Stress	158.72	139.08	.78	.440
Type A Profile	185.60	207.72	-2.80	.007

Note: *df*=49 in all cases.

the female mean of 4.82, this difference was not significant. On the BSRI Feminine Scale a significant between sex difference was observed ($p<.05$) with a female mean of 4.92 to the male mean of 4.51.

Table 9 presents the BSRI means from Bem's Stanford normative sample (Bem and Watson, 1976) and means from the sample of 114 Loyola undergraduates examined by Merrill (1979). Only the comparisons between the female groups on the masculine scale were examined. It was predicted that the female attorneys would achieve a significantly higher masculine socre than the undergraduates from Loyola and Stanford. The t-score for the different between the attorneys and the Stanford undergraduates was 1.86 which was significant at $p<.05$ ($df=303$). However, the difference between the female attorneys and the Loyola undergraduate women was not significant at $t=1.04$ ($df=81$).

Regarding the health and symptom admission measures, while there was a tendency for women to receive higher scores than men, in only one instance was this difference significant. Thus, women admitted to more symptoms of anxiety under stress; during the past year, women admitted to visiting the doctor more often, losing more sick days from work and suffering from a greater number of physical ailments than men. However, the number of physical ailments was the only aspect of illness behavior in which women differed significantly from men ($p<.01$).

TABLE 9

MEANS AND STANDARD DEVIATIONS ON THE BSRI FOR STANFORD AND LOYOLA UNDERGRADUATES AND D.C. ATTORNEYS

BSRI Masculine Scale

	D.C. Attorneys	Stanford Undergrads	Loyola Undergrads
		Men	
$\bar{X}$	5.12	4.97	5.02
N	25	444	57
SD	.66	.67	.62
		Women	
$\bar{X}$	4.82	4.57	4.65
N	25	279	57
SD	.62	.69	.77

BSRI Feminine Scale

		Men	
$\bar{X}$	4.52	4.44	4.57
N	25	444	57
SD	.53	.55	.42
		Women	
$\bar{X}$	4.92	5.01	5.12
N	25	279	57
SD	.62	.52	.51

Table 10 presents the Langner means from Merrill's sample of Loyola undergraduates. It is evident that the attorney group was considerably less willing to admit vulnerability to stress than the undergraduate group. Female attorneys admitted an average of 4.49 fewer symptoms than female undergraduates for a t-score of 5.27 ($p<.01$, $df=82$).

Finally, there are the surprising results of Bortner's Short Rating Scale of Type A behavior. According to Bortner's scale, the women attorneys were significantly more Type A ($p<.01$) than the men attorneys. In terms of interpretation, this scale is perhaps the most problematic in the present battery and will be examined more extensively in the Discussion.

Table 11 presents a correlation matrix of most of the significant variables and thus provides an overview of the relationships between the variables. Several relationships are worth noting. The three variables used to measure health behavior during the past year all show high correlations indicating a probable overlap in measuring the same phenomenon. However, regarding the relationship of general health to anxiety symptomatology, only ailments showed a significant relationship to number of anxiety symptoms experienced.

It would be expected that stress would exhibit a positive relationship with readiness to admit anxiety

TABLE 10

MEANS AND STANDARD DEVIATIONS ON THE
LANGNER MENTAL HEALTH SCALE
FOR LOYOLA UNDERGRADUATES AND D.C. ATTORNEYS

		Loyola Undergrads	D.C. Attorneys
Men	$\bar{X}$	7.36	4.6
	SD	2.9	3.7
	N	57	25
Women	$\bar{X}$	10.29	5.8
	SD	4.7	2.9
	N	57	25

TABLE 11

CORRELATION MATRIX OF ALL MAJOR VARIABLES

	Age	Years Out	Type A	Ailments	Days	Visits	BSRI Masc.	BSRI Fem.	Anxiety	Stress
Age		r=.69 p<.**	r=-.12	r=-.12	r=.02	r=-.05	r=-.03	r=-.41 p<.**	r=-.05	r=.03
Years Out			r=.05	r=-.05	r=.01	r=-.01	r=-.03	r=-.40 p<.**	r=.01	r=.03
Type A				r=.27 p<.**	r=.02	r=.05	r=.08	r=.09	r=.37 p<.**	r=.04
Ailments					r=.47 p<.**	r=.46 p<.**	r=-.08	r=.29 p<.**	r=.24 p<.0*	r=-.10
Days						r=.83 p<.**	r=-.13	r=.16	r=.10	r=-.05
Visits							r=-.08	r=.10	r=.10	r=-.14
BSRI Masculine								r=.06	r=-.22	r=-.14
Anxiety Symptoms									r=.04	r=-.14
Stress										r=.37

Note: Degrees of Freedom in all cases = 48

* Significant at $p < .05$
** Significant at $p < .01$

symptoms; this indeed was found in the present data. There were not, however, any significant relationships between stress and the three measures of health behavior which is contrary to expectations.

A relationship between the BSRI Feminine scale and admission of anxiety had been expected but was not found. There was a significant relationship between the BSRI Feminine Scale and Ailments (r=.29; p<.01) but not for the other measure of health behavior.

The BSRI masculine scale was not related to any of the three measures of health behavior. There was, however, an almost significant tendency (p<.07) for the BSRI Masculine Scale to be negatively related to the admission of anxiety.

Finally, it is interesting to note that there appears to be a tendency toward attrition in feminine identification with years since graduation, although number of years in the profession does not appear to be related to health behavior.

Tables 12 through 16 present the ANOVAs for the health variables. Due to the fact that the independent variables were related nonorthogonally, it was not possible to obtain equal cell frequencies, and a Least Squares Analysis of Variance was used to correct for this nonorthogonality. Only two levels of each independent variable were employed. Bem (1976) has recommended that the

TABLE 12

ANOVA ON NUMBER OF AILMENTS DURING THE PAST YEAR

Source	df	SS	MS	F	p	r-square
Model	4	40.94	10.23	3.73	.01	.25
Error	45	123.57	2.75			
Corrected Total	49	164.50				

SD = 1.66 $\quad\quad$ $\bar{X}$ = 3.30

Source	df	SS	F	p
BSRI MASC	1	5.39	1.96	.17
BSRI FEM	1	19.22	7.0	.01
LIFE STRESS	1	1.21	.44	.51
SEX	1	15.12	5.51	.02

TABLE 13

ANOVA ON NUMBER OF DAYS LOST FROM WORK DURING THE PAST YEAR

Source	df	SS	MS	F	p	r-square
Model	4	700.49	175.12	.97	.43	.07
Error	45	8105.53	180.12			
Corrected Total	49	8806.02				

SD = 13.42 $\quad\quad$ $\bar{X}$ = 4.86

Source	df	SS	F	p
BSRI MASC	1	.01	.00	.99
BSRI FEM	1	302.59	1.68	.20
LIFE STRESS	1	31.92	.18	.68
SEX	1	365.97	2.03	.16

TABLE 14

ANOVA ON NUMBER OF PHYSICIAN VISITS

DURING THE PAST YEAR

Source	df	SS	MS	F	p	r-square
Model	4	28.46	7.11	.83	.51	.07
Error	45	385.06	8.56			
Corrected Total	49	413.52				

SD = 2.92 $\quad\quad$ $\bar{X}$ = 1.64

Source	df	SS	F	p
BSRI MASC	1	.22	.03	.87
BSRI FEM	1	2.88	.34	.56
LIFE STRESS	1	12.00	1.40	.24
SEX	1	13.36	1.56	.22

TABLE 15

ANOVA ON ANXIETY SYMPTOM DISCLOSURE

Source	df	SS	MS	F	p	r-square
Model	4	63.08	15.77	1.43	.24	.11
Error	45	496.92	11.04			
Corrected Total	49	560.00				

SD = 3.32 $\quad\quad$ $\overline{X}$ = 5.20

Source	df	SS	F	p
BSRI MASC	1	25.39	2.30	.14
BSRI FEM	1	8.00	.72	.40
LIFE STRESS	1	19.50	1.77	.19
SEX	1	10.20	.92	.34

TABLE 16

ANOVA ON THE TYPE A PROFILE

Source	df	SS	MS	F	p	r-square
Model	4	7308.64	1827.16	2.27	.07	.17
Error	45	36154.58	803.66			
Corrected Total	49	43473.22				

SD = 28.35 $\quad \bar{X} = 196.66$

Source	df	SS	F	p
BSRI MASC	1	.11	.00	.99
BSRI FEM	1	364.50	.45	.50
LIFE STRESS	1	782.16	.97	.32
SEX	1	6161.82	7.67	.01

Masculine and Feminine Sex Role scales be scored according to a median split. This same median split demarcation was also used with the stress measure. Accordingly, the four variables under consideration had two levels: (1) Biological sex (males, females), (2) Masculine Sex Role Identification (low, high), (3) Feminine Sex Role Identification (low, high), (4) Life stress (low, high). Degrees of Freedom for all ANOVAs are 1,45.

Table 12 presents the ANOVA for the number of Ailments during the past year. The four variables under consideration account for 25 percent of the variance in this measure, and the model is significant at $F=3.73$ ($p<.01$). The factor which accounts for most of the variance is feminine sex role identification (BSRI FEM) with high feminine respondents revealing significantly more ailments than low feminine respondents. Biological sex also exerted a significant effect, with women revealing more ailments than men.

Table 13 presents the sums of squares for number of work days lost. The four variables under consideration accounted for only eight percent of the variance in the entire model which failed to reach significance at $F=.97$.

Table 14 presents the sums of squares for physician visits. Again, the model failed to reach significance at $F=.83$.

Table 15 presents the sums of squares for admission of anxiety symptomatology. The model fails to reach significance at $F=1.43$.

Finally, Table 16 presents the ANOVA for the Type A Behavior profile. This model almost reaches significance at $F=2.27$ ($p<.08$). Of the four factors examined, the only factor which exerted any appreciable impact on Type A behavior is biological sex.

CHAPTER VIII

DISCUSSION

The Relationship Between Professional Role and Sex Role Attitudes

The results of the present study tend to support the hypothesis of an interdependence between sex role and professional role. In terms of our hypothetical role pyramid, it appears that changes at the "work role" level do affect sex role identity at the highest level.

This conclusion is based on several factors. In the present study men and women did not differ significantly on the masculine scale of the BSRI. This lack of difference had been expected, based on the assumption that socialization in the competitive legal profession would foster identification with the masculine qualities of aggression, ambition, independence, etc. Critical support for the sex role/professional role relationship comes also from the finding that the female attorneys were significantly more masculine than the women in Bem's Stanford normative sample. They were also more masculine than the women in Merrill's sample of Loyola undergraduates, although this difference did not reach significance. This suggests that the academic and social

freedoms enjoyed by American women students do not equal the demands of a professional environment in terms of eliciting identification with masculine values. Despite the liberating influence of a university education, female students still tend toward a more traditional sex role identification than is characteristic of women professionals.

It is interesting to note that in all cases the female attorneys are more masculine and less feminine than the female students at Loyola and Stanford. Furthermore, the difference between men and women on both masculine and feminine scales of the BSRI is smallest in the attorney group. Although in the present study men and women continue to differ significantly on the BSRI feminine scale, this difference is smaller than that observed in the student groups. Also, in the present sample of professionals, identification with feminine values appears to decrease with socialization in the legal field as this is measured by years out of law school (r=-.40; $p < .01$; df=48). These findings raise the possibility that one pathway to androgyny may reside in the increasing professionalization of men and women. That is, as the work role responsibilities of men and women become more similar, so does their identification with sex-typed values which facilitate the fulfillment of those responsibilities.

Problems and Questions for Further Research

Although the relationship between sex role and professional role receives some support from the present study, this conclusion would have a firmer empirical basis if several problems which tend to obfuscate the present results could be resolved through further research. It is possible that women professionals are a pre-selected group and that their higher identification with masculine values occurred some time even before their admission to graduate school. Accordingly, women professionals' experiences in graduate school and on the job would have little to do with their higher identification with masculine values. This possibility could be examined by a cross sectional study which would examine groups of women at various points in the development of their professional careers. The ideal study would, of course, be a longitudinal study which would follow the same group of women through law school and six or seven years of professional experience.

The proposal of a longitudinal study raises another problem with the present study and that is the extreme homogeneity of the subject pool which extends to such variables as age. This is a very youthful group of attorneys; the modal age (ten respondents) is 27. Marriage and family information were not obtained in the present

study, but although it is probable that a number of the respondents are married, it is less likely, given their youthfulness, that many have children. These are factors which could critically affect sex role identification and need to be explored more fully. It is entirely possible that as many of these respondents begin to raise families their sex role attitudes will be characterized by a resurgence of identification with feminine values.

There is another reason why a more heterogeneous subject pool would be desirable and that is the likelihood that the differences in sex role identification would have emerged much more sharply if women attorneys had been compared with a group of nonprofessional women. Ideally, comparisons should be made with a number of groups, with housewives, with women who seem themselves as having "jobs" as opposed to "careers" or those women who see themselves as working primarily to supplement the family income. It would also be interesting to investigate single working women and single female heads of households.

The Relationship Between Sex Role and Sick Role in Men and Women Professionals

The principal focus of this study was on the relationship between sex role and sick role in men and women professionals. The theoretical premise was that the morbidity differences between men and women could be attributed in

part to the different characteristics of traditional masculine and feminine roles. A bipartite model of illness was adopted; it was composed of a relatively immutable physiological component and a flexible sociological component which has been labeled the sick role. The sick role sanctions the idleness or role dissertion of the incapacitated individual, thereby allowing him the time necessary for recuperation. But the sick role also functions to subtly stigmatize and alienate the sick individual thereby motivating him to return to productivity as soon as possible. A number of researchers have examined social selection processes resulting in differences between groups in willingness to accept the sick role. The present study attempted to investigate the hypothesis that sex role has constituted such a social selection factor.

As had been predicted, women generally did not differ from men on the measures of health behavior, with the exception of their significantly higher scores on the Ailments measure. It had also been expected that a significant relationship would emerge between illness behavior and sex role with high disclosure positively related to feminine sex role identification and negatively related to masculine sex role identification. As is evident from the ANOVAs presented in Tables 13, 14, 15 and 16, this objective was generally not achieved. In

one measure, however, the Ailments measure, the analysis of variance did achieve significance with two of the four factors, biological sex and feminine sex role identification exerting significant effects.[14]

Thus, the results are not definitive. In light of a wide variety of research which has shown women in general to exhibit a higher level of morbidity than men, the present results that show no significant difference between men and women on three of four measures of illness behavior constitute an important finding. There is very little support, however, for a positive relationship between feminine sex role values and willingness to accept the sick role, as this relationship was observed in only one of four measures.

---

[14]There may be some objections to interpreting the Ailments measure as an index of illness behavior to the effect that this measure is more appropriately interpreted as an index of actual health as distinguished from that area of behavior circumscribed by the sick role. It should be noted that if this alternative explanation is accepted, it only strengthens the theoretical position espoused by this study; viz., despite the fact that the women attorneys suffered from a higher number of illnesses, they did not differ significantly from their male colleagues in willingness to accept the sick role as this is measured by physician visits or days lost from work.

Furthermore, it should be noted that a number of researchers examining illness behavior have interpreted the actual reporting of symptoms in terms of sick role behavior. Thus Zborowski (1958) interpreted the apparently greater illness among Jewish and Italian inductees in terms of childhood illness training. Zola (1964) in his comparison of Irish and Italian patients examined the actual reporting of illness in terms of sick role behavior.

A closer look at the results does indicate that for all four measures of illness behavior, individuals with high feminine identification did receive higher scores than individuals with low feminine identification. Another consistent trend was for the 12 subjects in the high masculine/low feminine quarter to receive the lowest scores on all four measures of illness behavior.

These results raise the possibility that the distinctive female psychopathology profile which has emerged in the past 30 years--a profile characterized by higher neuroticism, anxiety and depression among middle-class women, leading them to seek hospitalization and therapy in greater numbers than middle-class men--is partially a consequence of sex role prescriptions which lend relatively more support to the acceptance of the sick role by women than by men. These prescriptions appear to have applied, however, to women in traditional feminine roles; that is, as homemaker and possibly low level employee, and not apparently to women entering traditionally masculine, professional roles. The present results suggest that women professionals are less willing to accept the sick role, less willing to present themselves as possible candidates for therapeutic assistance.

Self Disclosure and the Sick Role

Self disclosure plays a critical part in the self presentation involved in the sick role. In all but the most severe cases, it is the individual who initiates the process which results in his or her eventually being labeled as sick by disclosing physiological or psychological distress. Evidence that women have been more willing to accept the sick role can be adduced from research on self disclosure. Researchers using the popular Jouard Scale of Self Disclosure (Jouard, 1958) have tended to find that women disclose more than men (Cozby, 1973). In her preliminary research with the BSRI, Bem (1976) found a significant positive correlation between the BSRI Feminine Scale and the Jouard Scale which suggests that feminine sex role attitudes do play a part in the higher female self disclosure.

In her research with undergraduates, Merrill (1979) found that women scored higher on the Jouard than men. However, she did not find that this disclosure was exclusively related to high feminine identification. In fact, there was an even stronger tendency for individuals with high masculine identification to be high disclosers. However, when Merrill examined willingness to disclose symptoms of anxiety (on the Langner Scale), she found that the BSRI masculine scale was negatively correlated

with symptom admission. An analysis of variance on the Langner measure showed that high disclosers tended to be women with a high feminine identification. These results suggest that while masculine sex role attitudes do not necessarily mitigate against self disclosure of a more neutral or social variety, they do definitely inhibit the admission of weakness or anxiety.

Researchers have interpreted the higher anxiety scores of women in terms of the greater defensiveness of men. Sarason and his colleagues (Sarason, Lighthall, Davidson, Waite & Ruebush, 1960) developed several anxiety scales for children; in research with these instruments they found a general tendency for girls to score higher than boys. Yet in later work, Sarason et al. (Hill and Sarason, 1966; Hill and Zimbardo, 1964) noted that boys score higher on the lie scale and are less willing to admit weaknesses of various sorts than girls. These results raise the question of whether higher female anxiety scores actually reflect real underlying differences.

Phillips (1964, 1970) clearly sides with those theorists who believe that the real psychiatric morbidity of women is not as different from that of men as it may superficially appear. He has demonstrated that men are rejected more than women for exhibiting the same psychiatric symptoms. When the rejection factor is considered

along with the fminine "social expressiveness" factor, they amount to two powerful social reinforcers for higher apparent female morbidity. According to this argument, given the same set of symptoms, a woman is more likely to appeal for assistance or at least disclose her condition than a man.

The Weaker Sex?

Women have long been identified as the weaker sex, yet there is some evidence that higher female psychiatric morbidity is a recent, post World War II phenomenon. When mortality statistics are examined, the case for women as the weaker sex becomes even more clouded. Female life expectancy is presently 75 years, almost eight years longer than men's.

Although the case for higher female psychiatric morbidity is not as clearcut as certain writers assume, it is relatively clear that in the broad spectrum of the employed middle class, women have exhibited not only a higher rate of psychiatric morbidity than men, they have also exhibited a different pattern of morbidity. Among men, schizophrenia and alcoholism contend for the leading disorder, whereas among women depression is clearly the leading disorder accounting for almost 25 percent of all female psychopathology.

These statistics can be tentatively summarized in the statement that in the past World War II era, in modern industrial societies, middle class women have shown a tendency to have higher psychiatric morbidity and lower mortality than men. Furthermore, women's psychopathology appears to have consisted in large part of a syndrome which is characterized by helplessness. It is also a disorder which, compared to schizophrenia, is highly treatable.

A number of writers have argued that women's greater psychiatric morbidity is a result of the frustrations and humiliations they have endured as second class citizens in modern society. Yet it seems that these same statistics could be placed in the service of a different interpretation. Accordingly, in the last three decades, in a period of unprecedented national prosperity, women have had the opportunity to exercise particular concern about their physical and psychological well being. One result of this opportunity has been a dramatic drop in female mortality relative to male mortality at all age levels.

In terms of their psychological adjustment, have women been more unhappy, more frustrated, less well adjusted than men? They have been hospitalized more frequently, submitted to more therapy and a number of anxiety and mental health measures have indicated a higher degree of anxiety, uneasiness and depression in women.

These facts could indicate greater unhappiness, but they could also result from a situation where women had greater opportunity to become preoccupied with their mental health, from a situation where they had the leisure to engage in a number of self actualizing pursuits. What middle class women did not have the opportunity, or at least the set of social incentives, to do was enter the job market in a directly competitive relationship with men. Despite the importance of the family, this masculine world was accorded, by men and women alike, singular preeminence. This preeminence was reflected in the tendency observed by McKee and Sherriffs for men and women to value masculine traits more highly than feminine. In the fifties and sixties a number of social observers commented upon the role conflict which enmeshed many young women university graduates.

The Changing Structure of the American Family and Changing Patterns of Female Morbidity

The period in contemporary society where women's primary role is homemaker is passing. According to forecasts in a study sponsored by the Joint Center for Urban Studies at M.I.T. and Harvard, by the end of the 1980's, just over one quarter of all American households will be conventional families of mother, father and young children. In 1960, close to 50 percent of all households consisted

of mother, father and two or more children under the age of 15. Rising divorce rates and declining marriage and fertility rates have reduced the proportion of nuclear family households, and the trend is likely to continue. Only three to four million of the twenty million new households expected to be established between 1975 and 1990 will be married couples; the remaining households will be headed by the never-married; divorced or widowed population. One worker, husband-wife households will have fallen from 43 percent of all households in 1960 to 14 percent by 1990 (Ziemba, 1980).

It is not too much to expect that these changes would be reflected in the sex role attitudes of women and in other areas such as health behavior which may be related to sex role. It would be expected that working women and female single heads of households would have less opportunity to "cater" to their health. Women in the more competitive, professional careers may become aware of pressures to appear tough, independent and self reliant and the corresponding risks to advancement of appearing vulnerable, dependent and weak.

The pressures on working women will be considerable. Many of them will be expected to assume primary household responsibilities in addition to full time employment. Many will have to contend with a discriminatory job market where in all professional categories women presently earn

an average salary considerably lower than men's. It would not be surprising for these strains to manifest themselves in women's physical and emotional adjustment. Yet is is likely that these manifestations will tend toward patterns typical of "masculine" pathology and away from patterns of typical feminine pathology, toward alcoholism, away from depression.

A number of social observers believe that these changes are well under way. Federal health officials estimate that one of three Americans with a drinking problem is a woman, compared with only one of six a decade ago. Smoking is increasing among women; from 1965 to 1978, while the percentage of adult men who smoke was dropping from more to half to just 37 percent, the figure for women held almost unchanged at about 30 percent. Women smokers who are employed tend to inhale more than women smokers who aren't, according to the U.S. Surgeon General's Report. Lung cancer is increasing so rapidly among women that it is expected to overtake breast cancer by the mid 1980's as their leading cancer killer. Since 1968, deaths from heart disease have been falling faster for men than for women. The trend is believed to reflect the changing patterns of smoking. It also may reflect job stress. A recent study by the National Heart, Lung and Blood Institute found that middle aged working mothers

dissatisfied with their clerical and sales jobs were twice as likely to develop heart disease as housewives.

In 1962, four times as many male as female drivers were involved in crashes. By 1977, the ratio had narrowed two-to-one. The main reason appears to be a doubling of the number of women drivers. In the area of suicide, the gap is also narrowing. Suicide prevention centers indicate that would-be female suicides, who often in the past have taken drug overdoses and been revived, increasingly use lethal and historically male methods of suicide, such as hanging, gunshots and deliberate car crashes.

The possibility that the increase of masculine, "acting out" pathology among working women is accompanied by a decrease in feminine neuroticism and in fact represents a supplanting of the one by the other is clearly at the highly speculative stage. Such a conclusion cannot be drawn from the results of the present study which suggest little more than that even relatively well established patterns of psychopathology are not immutable. The small group of women attorneys examined here differ from the general population of women in that their illness behavior was not appreciably different from that of their male colleagues. However, this finding raises further questions and invites speculation. For example, is the incidence of depression lower among professionals and working women

than among housewives? If this is the case, isn't it likely that the coming decade will witness a decrease in the rate of female cases of depression approaching that of male cases of depression?

The research of Broverman et al. (1970) has shown that sex role prescriptions are significantly involved in defining pathological behavior. The present study has focussed on the self selection or self presentation factor in illness and has presented evidence that role prescriptions exert a mediating influence on willingness to accept the sick role. Consequently, sweeping changes in role prescriptions might very well result in comparable changes in patterns of psychopathology.

Problems and Suggestions for Further Research

The finding that women attorneys did not differ from their male colleagues regarding illness behavior is important, but a more comprehensive interpretation requires the examination of comparison groups of other women. The illness behavior of professional women needs to be compared with that of housewives, of low level female employees, of single female heads of households, etc. Furthermore, it is important that a more variegated sample of professional women be examined. The present subject pool was limited by its extreme homogeneity which may well have functioned

to suppress relationships which would have emerged in a more heterogeneous sample. This group of attorneys was distinguished not only by its youthfulness but also by its unusual degree of dedication. It is not a little astonishing to note that the median number of days lost from work for illness during the past year was 1.25, and the modal number, marked by 16 individuals, was actually zero.

Finally, the striking results on the Bortner Scale of Type A Behavior[15] suggest that future researchers may not be able to rely on standard measures of stress when examining professional women. In the present study the results of four illness measures and one life stress measure indicated that there was very little difference between men and women in terms of experienced stress. Yet the women's significantly higher mean score on the

---

[15]The validity of the Type A profile is sufficiently tenuous to make it unadvisable to interpret these results in terms of heart attack proneness. Mordkoff and Parsons (1967) have pointed out that much of the research on the Type A syndrome is uncontrolled and even in controlled studies mental status has often been assessed only after the disease occurred. Friedman, Ory, Klatsky and Siegelaub (1972) in an extensive study were able to examine the records of patients who had had a multiphasic health checkup prior to their myocardial infarction (MI). Subjects were matched with two control groups. Three established experts on the Type A syndrome were asked to select from the multiphasic health questionnaire those items which isolated the MI patients. Other than identifying a possible tendency for anxiety-neuroticism to be a predictor of MI in symptom free individuals, the experts completely failed the task. This led Friedman et al. to conclude that, "...our study seems to provide little support to current theories as to psychological mechanisms predisposing to or predictive of MI."

Bortner Scale raises the possibility that they experience themselves to be under more stress and pressure than their male colleagues. Given their status as a minority group in a highly competitive field dominated by men, this feeling may have a very realistic foundation, but the fact remains that it did not register on several other conventional measures of life stress.

There is much that is unique to the situation of the working woman, and this uniqueness requires particular sensitivity on the part of the researcher. The principal distinction stems from the situation that most working women continue to occupy two roles which frequently come into conflict. This is particularly true of working mothers of young children. The problems they experience in juggling a career and household are rarely experienced in the same degree by their male colleagues. Meaningful research on the working woman needs to be alert to these differences.

REFERENCE NOTES

Merrill, K. An investigation into the relationship between sex role attitudes and sex-typed behaviors. Unpublished Master's Thesis. Loyola University of Chicago, 1979.

REFERENCES

Anderson, O.W. & Anderson, R.M. Patterns of use of health services. In H.E. Freeman, S. Levine & L.G. Reeder (eds.) Handbook of Medical Sociology (2nd ed.). 386-406, Prentice Hall, Inc., New Jersey, 1972.

Bem, S.L. On the utility in alternative procedures for assessing psychological androgyny. Journal of Consulting and Clinical Psychology, 1977, 45, 196-205.

Bem. S.L. & Watson, C. Scoring Packet: BSRI Revised 4/76.

Bem, S.L., Martyna, W. & Watson, C. Sex typing and androgyny: Further explorations of the expressive domain. Journal of Personality and Social Psychology, 1976, 34, 1016-22.

Bem, S.L. Sex role adaptability: One consequence of psychological androgyny. Journal of Personality and Social Psychology, 1975, 31, 633-43.

Bem, S.L. Androgyny vs. the tight little lives of fluffy women and chesty men. Psychology Today, 1975, 9, 58-62.

Bem, S.L. The measurement of psychological androgyny. Journal of Consulting Psychology, 1974, 42, 155-62.

Beck, A. & Greenberg, R. Cognitive therapy with depressed women. In Franks, V. and Burtle, V. (eds.) Women in Therapy, New York, Brunner/Mazel, 1974, 113-131.

Block, J.H. Sex role and socialization patterns: Some personality concommitants and environmental antecedents. Journal of Consulting and Clinical Psychology, 1973, 41, 321-41.

Bloom & Wilson. Patient practitioner relationships. In Freeman, H.E., Levine, S. and Reeder, L.G. (eds.) Handbook of Medical Sociology (2nd ed.) 224-40, New Jersey, Prentice Hall, Inc., 1972.

Bortner, R.W. A short rating scale as a potential measure of pattern A behavior. Journal of Chronic Diseases, 1969, 22, 87-91.

Broverman, I.K., Broverman, D.M., Rosenkrantz, P.S. & Vogel, S.R. Sex role stereotypes and clinical judgments of mental health. Journal of Consulting and Clinical Psychology, 1962, 26, 438-40.

Buhn, A.K., Conwell, M. & Hurley, P. Survey of private psychiatric practice. Archives of General Psychiatry, 1965, 34.

Chafetz, J.S. Masculine, Feminine or Human? An Overview of the Sociology of Sex Roles. Peacock Publishers, 1974.

Chesler, P. Women as psychotherapeutic patients. Journal of Marriage and the Family, 1971, 33, 746-59.

Constantinople, A. Masculinity-feminity: An exception to a famous dictum. Psychological Bulletin, 1973, 80, 389-407.

Cozby, P.C. Self disclosure: A literature review. Psychological Bulletin, 1973, 73-91.

Croog, S.H. Ethnic origins, educational level and responses to a health questionnaire. Human Organization, 1961, 20, 65-59.

Dahlstrom, W.G. & Walsh, G.S. An MMPI Handbook, University of Minnesota Press, Minneapolis, 1960.

Dohrenwend, B.P. & Dohrenwend, B.S. Social Status and Psychological Disorder: A Causal Inquiry. Wiley Interscience, New York, 1969.

Friedman, G.P., Ury, H.K., Klatsky, A.L. & Siegelaub, A.B. A psychological questionnaire predictive of myocardial infarction: Results from the Kaiser-Permanente epidemiologic study of myocardial infarction. Psychosomatic Medicine, 1974, 36, 327-43.

Frieze, I.H., Parsons, J.E., Johnson, P.B., Ruble, D.H. & Zellman, G.L. Women and Sex Roles: A Social Psychological Perspective. W.W. Norton and Company, New York, 1978.

Goldhamer, H. & Marshall, A. Psychosis and Civilization: Two Studies in the Frequency of Mental Disease. Free Press, Glencoe, Illinois, 1953.

Gordon, G.A. Role Theory and Illness: A Sociological Perspective. College and University Press, New Haven, Connecticut, 1960.

Gove, W.R. & Tudor, J.F. Adult sex roles and mental illness. American Journal of Sociology, 1973, 78, 812-35.

Gove, W.R. Sex, marital status and mortality. American Journal of Sociology, 1973, 79, 45-67.

Graham, J.R., Shroeder, H.E. & Lilly, R.S. Factor analysis on the social introversion and masculinity-femininity scales of the MMPI. Journal of Clinical Psychology, 1971, 27, 367-70.

Gump, J.P. Sex role attitudes and psychological well being. Journal of Social Issues, 1972, 28, 79-92.

Gurin, G., Veroff, J. & Field, S. Americans View Their Mental Health. New York, Basic Books, 1960.

Gutmann, D. Women and the conception of ego strength. Merrill Palmer Quarterly, 1965, 11, 229-40.

Harrison, E. The working woman: Barriers in employment. Public Administration Review, 1964, 24, 78-85.

Hathaway, S.R. & McKinley, J.C. Minnesota Multiphasic Personality Inventory, New York, Psychological Corporation, 1943.

Heilbrun, A.B. Sex-role, instrumental expressive behaviors and a psychopathology in females. Journal of Abnormal Psychology, 1968, 73, 131-36.

Heilbrun, A.B. Conformity to masculinity-femininity stereotypes and ego identity in adolescents. Psychology Reports, 1964, 14, 351-57.

Holmes, T.H. & Rahe, R.H. The social readjustment rating scale. Journal of Psychosomatic Research, 1967, 11, 213-18.

Landis, C. & Page, T. Modern Society and Mental Disease, New York, Farrer & Rinehart, 1938.

Langner, T. & Michael, S. Life Stress and Mental Health: The Midtown Manhattan Study, Vol. 2. The Free Press, New York, 1963.

Langner, T.S. A twenty two item screening scale of psychiatric symptoms indicating impairment. Journal of Health and Human Behavior, 1962, 3, 269-76.

Jenkins, C.D. Psychological and social precursors of CHD. New England Journal of Medicine, 1971, 284, 244-55, 307-17.

Koos, E. The Health of Regionsville: What the People Thought and Did About It. Columbia University Press, New York, 1954.

Kreps, J. Sex in the Marketplace. American Women at Work. Johns Hopkins Press, Baltimore, 1971.

Leighton, D. The Nature and Transmission of the Genetic and Cultural Characteristics of Human Populations. Milbank Memorial Fund, New York, 1963.

Leighton, D., Leighton, A. & MacMillan, A. The Character of Danger. Basic Books, New York, 1963.

Lublin, L.S. Cost of equality: As women's roles grow more like men's, so do their problems. Wall Street Journal, Jan. 14, 1980, p. 1, 19.

Maccoby, E.E. and Jacklin, C.N. The Psychology of Sex Differences. Stanford University Press, Stanford, California, 1974.

Maccoby, E.E. & Masters, J. Attachment and dependency. In Mussen, P. (ed.) Carmichael's Manual of Child Psychology, Vol. 2, New York, Wiley, 1970, 73-157.

Manis, J., Brawer, M., Hunt, C. & Kercher, L. Validating a mental health scale. American Sociological Review, 1963, 28, 84-89.

Mausner, J.S. & Steppacher, J.C. Suicide in professionals: A study of male and female psychologists. American Journal of Epidemiology, 1973, 98, 436.

McKee, J.P. & Sherriffs, A.C. Men's and women's beliefs, ideals and self concepts. American Journal of Sociology, 1959, 64, 356-63.

McKee, J.P. & Sherriffs, A.C. Qualitative aspects of beliefs about men and women. Journal of Personality, 1957, 25, 451-64.

McKee, J.P. & Sherriffs, A.C. The differential evaluation of males and females. Journal of Personality, 1957, 25, 356-71.

McKee, J.P. & Sherriffs, A.C. Sex differences in attitudes about sex differences. Journal of Psychology, 1953, 35, 161-68.

Mechanic, D. & Volkart, E. Illness behavior and medical diagnosis. Journal of Health and Human Behavior, 1961, 1, 51-58.

Mechanic, D. Religion, religiousity and religious behavior: The special case of the Jews. Human Organization, 1963, 22, 202-208.

Mechanic D. & Volkart, E. Stress, illness behavior and the sick role. American Sociological Review, 1961, 26, 51-58.

Mechanic D. Medical Sociology. The Free Press, New York, 1968.

Mechanic D. The concept of illness behavior. Journal of Chronic Diseases, 1961, 15, 189-94.

Mordkoff, A.M. & Parsons, O.A. The coronary personality: A critique. Psychosomatic Medicine, 1967, 29, 1-14.

Monohan, L., Kuhn, D. & Shaver, P. Intrapsychic vs. cultural explanations of the fear of success motives. Journal of Personality and Social Psychology. 1974, 29, 60-64.

Muller, T.S. Discussion of Langner's psychiatric impairment scale: A short screening device. American Journal of Psychiatry, 1971, 128, 601.

Mussen, P.H. Long term consequences of masculinity of interests in adolescents. Journal of Clinical and Consulting Psychology, 1962, 26, 435-40.

Nichols, R.C. Subtle, obvious and stereotypic measures of masculinity-femininity. Educational and Psychological Measurement, 1962, 22, 449-61.

Parsons, T. The Social System. The Free Press, New York, 1951.

Parsons, T. Definitions of health and illness in light of American values and social structure. In E.G. Jaco (ed.) Patients, Physicians and Illness, The Free Press, New York, 1972, 107-26.

Phillips, D. Self reliance and the inclination to adopt the sick role. Social Forces, 1965, 43, 555-63.

Phillips, D. Rejection of the mentally ill: The influence of behavior and sex. American Sociological Review, 1964, 29, 679-87.

Phillips, D. & Segal, B. Sexual status and psychiatric symptoms. American Sociological Review, 1969, 34, 58-68.

Phillips, L. & Rabinovitch, M. Social role patterns and symptomatic behaviors. Journal of Abnormal Psychology, 1958, 57, 181-86.

Radloff, L.S. Sex differences in Depression: The effects of occupational and marital status, Journal of Sex Roles, 1975, 1, 249-63.

Radloff, L.S. & Monroe, M.K. Sex Differences in Helplessness--with implications for depression. In Hansen, L.S. & Rapoza, R.S. (eds.) Career Development and Counseling in Women, Springfield, Illinois, Charles Thomas, 1968.

Raskin, A. & Golob, R. Occurrence of sex and social class differences in premorbid competence. Symptom and outcome measures in acute schizophrenia. Psychological Reports, 1966, 18, 11-22.

Roberts, R.E., Forthoffer, R.N. & Fabrega, H. Further evidence of dimensionality of the index of psychophysiological stress. Social Science and Medicine, 1974, 10, 483-90.

Rosenkrantz, P. Vogel, S., Bee, H. Broverman, I. & Broverman, D. Sex role stereotypes and self concepts of college students, Journal of Consulting and Clinical Psychology, 1968, 32, 287-95.

Schofield, W. Psychotherapy: The Purchase of Friendship. Englewood Cliffs, New Jersey, Prentice Hall, 1963.

Seiler, L.H. The twenty two item scale used in field studies of mental illness: A question of method, a question of substance, a question of theory. Journal of Health and Social Behavior, 1973, 14, 252-64.

Shader, R., Ebert, M. & Harmatz, J. Langner's psychiatric impairment scale: A short screening device. American Journal of Psychiatry, 1971, 128, 596-60.

Silverman, C. The Epidemiology of Depression. Johns Hopkins Press, Baltimore, 1968.

Spence, J.T. The personal attributes questionnaire: A measure of sex role stereotypes and masculinity-femininity. JSAS. Catalogue of Selected Documents in Psychology, 1974, 4, 1-43.

Spence, J.T., Helmreich, R. & Stapp, J. Ratings of self and peers on sex role attributes and their relationship to self esteem and conceptions of masculinity and femininity. Journal of Personality and Social Psychology, 1975, 32, 29-39.

Srole, L., Langner, T., Michael, S., Opler, M. & Rennie, T. Mental Health in Metropolis: The Midtown Study, Vol. 1. New York, McGraw-Hill, 1962.

Steppacher, R.C. & Mausner, J.S. Suicide in male and female physicians. Journal of the American Medical Associations, 1974, 228, 323.

Sternglanz, S.H. & Serbin, L.A. Sex role stereotyping in children's television programs. Developmental Psychology, 1974, 10, 710-15.

Strong, E.K. Interests of men and women. Journal of Social Psychology, 1936, 7, 49-67.

Suchman, E.A. Sociomedical variations among ethnic groups. The American Journal of Sociology, 1964, 70, 319-31.

Szaz, T. Schizophrenia: The Sacred Symbol of Psychiatry. New York, Harper and Row, 1976.

Terman, L. and Miles C. Sex and Personality. McGraw-Hill, New York, 1936.

U.S. Bureau of the Census. Patients in Mental Institutions, 1938. Government Printing Office, 1941.

U.S. Bureau of the Census. Mental Patients in State Hospitals, 1926 and 1927. Government Printing Office, Washington, D.C., 1930.

U.S. Department of Health, Education and Welfare. Mental Health Statistical Note 137. Primary Diagnosis of Discharges from Non-Federal General Hospitals of Psychiatric Inpatient Units, United States, 1975.

U.S. Department of Health, Education and Welfare. Mental Health Statistical Note 138. Diagnostic Distribution of Admissions to Inpatient Services of State and County Mental Hospitals, United States, 1975.

U.S. Department of Health, Education and Welfare. Statistical Note 81. Differential Utilization of Psychiatric Facilities by Men and Women, United States, 1970.

U.S. Department of Labor and Department of Health, Education and Welfare. Manpower Report of the President, transmitted to Congress, April, 1975. U.S. Government Printing Office, Washington, D.C., 1975.

U.S. Department of Labor, Wage and Labor Standards Administration, Women's Bureau, 1969 Handbook on Women Workers (Women's Bureau Bulletin, 294). U.S. Government Printing Office, Washington, D.C. 1969.

Waldron, I. Why do women live longer than men? Social Science and Medicine, 1974, 10, 349-60.

Zborowski, M. Cultural components in response to pain. In E.G. Jaco (ed.) Patients, Physicians and Illness, Free Press, New York, 1958, 256-68.

Ziemba, S. The vanishing family: New look for the 90's. The Chicago Tribune, June 8, 1980, 1, 14-15.

Zola, I. Culture and symptoms: An analysis of patients presenting complaints. American Sociological Review, 31, 615-30.

APPENDIX A

THE SOCIAL READJUSTMENT RATING SCALE

Directions:

The following list contains a number of disruptive life events. Please indicate by marking an "X" which events you have experienced during the past year.

___Marriage

___Troubles with boss

___Detention in jail or other institution

___Death of spouse

___Major change in sleeping habits

___Death of a close family member

___Major change in eating habits

___Foreclosure on a mortgage or loan

___Revision of personal habits (dress, manners, associations, etc.)

___Death of a close friend

___Minor violations of the law (e.g., traffic tickets, jay walking, disturbing the peace, etc.)

___Outstanding personal achievement

___Pregnancy

___Major change in the health or behavior of a family member

___Sexual difficulties

___In-law troubles

___Major change in the number of family get-togethers

___Major change in financial state

___Gaining a new family member

___Change in residence

___Son or daughter leaving home

___Marital separation from mate

___Major change in church activities

___Marital reconciliation with mate

___Being fired from work
___Divorce
___Changing to a different line of work
___Major change in the number of arguments with spouse
___Major change in responsibilities at work
___Wife beginning or ceasing work outside the home
___Major change in working hours or conditions
___Major change in usual type and/or amount of recreation
___Taking on a mortgage greater than $15,000
___Taking on a mortgage or loan less than $15,000
___Major personal injury or illness
___Major business readjustment
___Major change in social activities
___Major change in living conditions
___Retirement from work
___Vacation
___Changing to a new school
___Beginning or ceasing formal schooling

BORTNER'S SHORT RATING SCALE OF

TYPE A BEHAVIOR

Directions:

On this and the following page you will find 14 pairs of personality statements. Each pair identifies the extreme values of a particular personality characteristic. Please indicate by drawing a vertical line where you belong on the line between these two extremes.

Never late	/_____/_____/_____/_____/_____/_____/	Casual about appointments
Not competitive	/_____/_____/_____/_____/_____/_____/	Very competitive
Anticipates what others are going to say (nods, interrupts, finishes for them)	/_____/_____/_____/_____/_____/_____/	Good listener, hears others out
Always rushed	/_____/_____/_____/_____/_____/_____/	Never feels rushed, even under pressure
Goes "all out"	/_____/_____/_____/_____/_____/_____/	Casual
Takes things one at a time	/_____/_____/_____/_____/_____/_____/	Tries to do many things at once, thinks about what to do next

/ / / / / / /

Emphatic in speech (may pound desk) — Slow, deliberate talker

/ / / / / / /

Wants good job recognized by others — Only cares about satisfying self, no matter what others may think

/ / / / / / /

Fast (eating, talking, etc.) — Slow doing things

/ / / / / / /

Easy going — Hard driving

/ / / / / / /

"Sits" on feelings — Expresses feelings

/ / / / / / /

Many interests — Few interests outside work

/ / / / / / /

Not particularly ambitious — Ambitious

/ / / / / / /

Can wait patiently — Impatient when waiting

THE LANGNER MENTAL HEALTH SCALE

Directions:

The list below contains 22 behaviors, sensations and feelings which are typically associated with some form of stress. I would like you to indicate which of these sensations you tend to experience when you are exposed to a certain amount of stress or pressure. It might be helpful for you to reflect on certain trying times in your life--preparing for court, meeting deadlines, disappointments, rejections, etc.--and try to remember how you felt at that time. If you tend to experience a particular sensation or feeling on such occasions, simply mark an "X" on the adjacent line.

___Feel weak

___Couldn't get going

___Low spirits

___Feel hot all over

___Heart beating hard

___Poor appetite

___Restless

___Worrying type

___Shortness of breath

___Nervous

___Fainting spells

___Trouble sleeping

___Acid stomach

___Memory not all right

___Cold sweats

___Hands tremble

___Fullness in head

___Worries get me down

___Feel apart

___Nothing turns out

___Pains in head

___Nothing seems worthwhile

THE HEALTH QUESTIONNAIRE

Directions:

The purpose of this form is to acquire a general picture of your health during the past year. The list below is not intended to be all inclusive, but has been provided as an aid to your memory. Space has also been provided for conditions not listed here. Place a check (✓) beside any illness or incapacity which you have experienced during the past year. If the condition resulted in a visit to your physician and/or a loss of work time, please indicate this as well.

Condition	No. lost work days	Physician's Consultation

Respiratory Conditions:

___Common cold

___Influenza

___Pneumonia

___Bonchitus

___Other resp. conditions (please list)

Digestive System Conditions:

___Dental conditions--routine check-up, cavities

___Dental conditions--surgery

___Gastrointestinal disorders

___Ulcers

___Other digestive system conditions (please list)

Condition	No. lost work days	Physician's Consultation
Injuries:		
___Fractures and dislocations		
___Sprains and strains		
___Open wounds and lacerations		
___Contusions and superficial injuries		
___Other injuries		
___Diseases of the ear		
___Headaches		
___Genitourinary disorders		
___Pregnancy		
___Skin disease		
___Allergies		
___Arthritus		
___Asthma		
___Diabetes		
___Heart trouble		
___Hemorrhoids		
___Hernia		
___High blood pressure		
___Menstrual cramps		
___Repeated trouble with back or spine		
___Sinus trouble		
___Other conditions not listed here (please list)		
___Any conditions requiring surgery (please list)		

APPENDIX B

800 4th St. S.W. N-802
Washington, D.C. 20024
484-0735

Dear Attorney:

Thank you for consenting to take part in my study. What I am requesting is that you fill out the forms on the attached sheets. The entire series is not extensive, and I am relatively confident that completing it will not require more than 20 minutes of your time.

You may have some concerns about confidentiality and the use to which this material is to be put. In brief, your answered questionnaire will, along with 50 to 60 others, form the data base for my dissertation. This data will be analyzed and presented as a group; at no point in the dissertation will single cases be selected for presentation. Your anonymity is assured by the fact that I do not know who you are and I don't ask for your name; your questionnaire materials will be identified by number.

I am unwilling at this point to divulge the "purpose" of this study for fear that it might bias your response. Once I have collected the data, however, I would be happy to provide a brief explanatory summary for anyone interested.

Instructions are provided with each questionnaire. Please take care to respond as accurately as possible. I would appreciate it if you would complete the questionnaire at one sitting so as to mitigate the influence of differing external factors. When you have completed the form, place it in the attached envelope and mail it to me. I would appreciate your completing the form as soon as possible, but I need it by July 20th at the latest.

Thank you very much for your participation. It constitutes the core of my disseration and I am extremely grateful.

Sincerely,

Kimberly E. Merrill

APPROVAL SHEET

The dissertation submitted by Kimberly E. Merrill has been read and approved by the following committee:

Dr. Alan DeWolfe, Professor,
Psychology, Loyola

Dr. John Shack, Professor,
Psychology, Loyola

Dr. Jill Nagy, Assistant Professor,
Psychology, Loyola

The final copies have been examined by the director of the dissertation and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the dissertation is now given final approval by the Committee with reference to content and form.

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosphy.

12/11/80
Date

Director's Signature